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# Crisis Clinician's Lived Experience of Clinical Supervision

Elizabeth A. Sysak

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CRISIS CLINICIANS' LIVED EXPERIENCE OF CLINICAL SUPERVISION

A Dissertation

Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for  
the degree of Doctor of Philosophy

By

Elizabeth A. Sysak, M.S.Ed

December 2014

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2014

**DUQUESNE UNIVERSITY**  
**SCHOOL OF EDUCATION**  
**Department of Counseling, Psychology and Special Education**

***Dissertation***

Submitted in Partial Fulfillment of the Requirements  
For the Degree of Doctor of Philosophy (Ph.D.)

**Executive Counselor Education and Supervision Program**

***Presented by:***

Elizabeth A. Sysak

**October 23, 2014**

CRISIS CLINICIAN'S LIVED EXPERIENCE  
OF CLINICAL SUPERVISION

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## ABSTRACT

### CRISIS CLINICIANS' LIVED EXPERIENCE OF CLINICAL SUPERVISION

By

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December 2014

Dissertation supervised by Dr. William Casile.

Crisis intervention first responders experience both small and large-scale disasters that can leave lasting negative impacts on crisis clinicians. However, little is known about how clinicians receive support for their personal and professional well being in clinical supervision. This hermeneutic phenomenological study explored the lived experience of crisis clinicians to understand how and if they receive support through clinical supervision in their work in crisis intervention. This study found that crisis clinicians struggle to manage the complex emotions that accompany the unique work of crisis intervention. This study also found that crisis clinicians are not receiving the support they need in clinical supervision.

## DEDICATION

This dissertation is dedicated to my Nuni, who never doubted for a moment that I would accomplish this dream.

## ACKNOWLEDGMENTS

This was not a solo journey. I am blessed beyond belief to have many people who have walked this road with me. Their constant love, encouragement, support, and humor carried me through at every point when I felt like I had no more to give.

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## CHAPTER I

### INTRODUCTION

*“It is one of the most beautiful compensations in life that no one can sincerely try to help another without helping himself.”*

—Ralph Waldo Emerson

If you were to ask clinicians working in the field of mental health or counseling why they chose to do this work, the majority would tell you that it’s because they have a true passion for helping others. There is value and reward in leaving someone a little better than you found them, knowing that your presence and support might have played an important part in improving someone else’s life. Although the field of counseling and mental health inevitably entails long hours and intense emotional work, there are helpers who are intrinsically motivated to counsel and support people in vulnerable moments for a variety of reasons, and many do it out of a genuine desire to help someone. Clinicians who make a decision to enter this field choose to dedicate time and resources for the benefit of someone else, while oftentimes setting their own needs aside in order to remain fully present and attentive for the client.

Crisis intervention clinicians enter the field for the purpose of assisting people in vulnerable moments, but at what expense? We watch movies with characters who experience trials and tribulations and evoke painful emotions, entering their world for a few hours, but we can turn that movie off. We can choose to exit that world if it becomes overwhelming. In crisis work and in the counseling field in general, we can’t simply turn off a situation until we have finished the intervention. We enter into this field knowing some of the consequences, but do we really understand all the potential ramifications of being a helper? We all carry some baggage with us from places we have traveled and

experiences that have shaped us into the person and professional we have become. The baggage and experiences, whether positive or negative, can impact every choice we make, and it's important to consider where to place that baggage when it is our job to tend to someone else. The well-known notion of helping yourself before helping others is advice we dispense but seldom adopt as professional helpers. The central inquiry of this study is, who helps the helper? How do people take care of themselves in order to effectively take care of others? Do the layers within the system of counseling support people on the front line to ensure that they are being supported both professionally and personally? How does clinical supervision play a part in both guidance and support for the clinician's professional competence as well as his or her personal well-being?

### **Significance of Study**

This study used crisis clinicians' lived experiences as the means to extract rich detail and interpretation in order to better understand the phenomenon of clinical supervision in crisis intervention work. Van Manen (1984) suggested, "As we research the possible meaning structures of our lived experiences, we come to a fuller grasp of what it means to be in the world as a man, a woman, a child, taking into account the sociocultural and the historical traditions which have given meaning to our ways of being in the world" (p. 38). Exploring the lived experience provides a unique and important perspective to learn the phenomenon from the inside out in order to better grasp the phenomenon as a whole. We often meander through this world and do what is required of us without fully thinking through all aspects of the experience; this study provided a vehicle for clinicians to describe and help the researcher understand the meaning of the experience of their daily routines at work. Van Manen (1984) stated, "So, phenomenology like poetry is a



poetizing project: it tries an incantative, evocative speaking, a primal telling, wherein we aim to involve the voice into an original singing of the world” (p. 39). This study is significant in that it used a unique lens to view the phenomenon and to engage participants who have actual day-to-day experience with it. The data were generated from the participants who do this work on a daily basis, their life experience. The information gathered in this study lays important groundwork for both crisis clinicians and supervisors to examine their work and its value in the field of crisis intervention. Additionally, there is inherent value for the participants in this study to reflect on their own lived experiences as it impacts their day-to-day work as crisis clinicians. The significance of this study impacts several levels of professionals within the field, including crisis clinicians, clinical supervisors, and counselor educators.

### **Crisis Clinicians**

“Oh, God. Emergency.” those were the last words uttered by the pilot to the air traffic controller on Flight 427 from Chicago to Pittsburgh. On September 8, 1994, U.S. Airlines Flight 427 plummeted to the ground while traveling over 300 miles per hour. All that was left after the tragic accident were pieces of the 127 passengers and 5 crewmembers who had lost their lives that day. First responders, including paramedics, firefighters, police officers, and crisis intervention response teams, rushed to the scene. One responder commented, “I saw fingers with rings on them and stepped on an eyeball. I’ve been to many crashes but nothing like this” (Norman Ferrence). Many responders explained that the human debris was comparable to something they would have witnessed in Vietnam. It was near impossible to identify people based on what was found at the scene of the accident. The smell of human flesh and blood was so strong that everyone in the vicinity

of the crash site wore earplugs because the olfactory senses in people's ears could detect the scent. The scene was declared a biological hazard because of the amount of blood, and the first responders wore jumpsuits, rubber boots, helmets, masks, and ear and nose plugs to protect themselves against the conditions. The protective gear was not enough to prevent the nightmares and the flashbacks that invaded many of the first responders' memories for years after the incident. Large-scale crises, such as that seen with Flight 427, are just one type of event that requires a response from crisis intervention teams.

The terrorist attacks on September 11, 2001, gained national attention, and the media brought the topic of crisis response to the forefront. The final death toll of the horrific tragedy landed at 2,838 individuals, and the suddenness and severity of the incident highlighted the need for mental health professionals and crisis intervention programs (Roberts, 2002). The attacks on the World Trade Center served as a profound and chilling reminder that crises and disasters are inevitable. Thousands of crisis response units around the country arrived in New York to assist in supporting families, friends, witnesses, and other first responders. Crises and disasters occur every day, but none received the same amount of worldwide attention as the attacks of September 11. A crisis occurs when a stressful event overwhelms people's ability to cope (Auerbach & Killman, 1997; Everly & Flannery, 1999).

Crises can also occur on a much smaller scale. A variety of events, such as domestic violence, substance abuse, homicide, and suicide, can impair people's ability to effectively cope. A crisis is a disruption to psychological homeostasis where typical coping mechanisms no longer work (Everly & Flannery, 1999; Roberts, 2005). A crisis intervention response team can work with an individual who is struggling with addiction

and does not know where to turn for help and then work with a family whose father just completed suicide all in the same day. Regardless of whether it is a large or small-scale crisis, if there is impact that is stressful and disrupts routine then there is the potential for a response by a crisis intervention team (Everly & Mitchell, 1999; Roberts, 2002). The personal impact after a stressful incident, regardless of the size of the event, can be measured in spatial dimensions, subjective time clock, and perceived reoccurrence (Roberts, 2002). Spatial dimension refers to the people closer to the center of the event who typically experience greater stress levels. Similarly, spatial dimension includes people who have a closer relationship to the victims of the tragedy. The wife of a man who completed suicide will experience a more intense impact than the man's neighbor. The subjective time clock addresses the fact that the longer a person is exposed to an event, particularly sensory experiences, the more stress impact the person will feel. With regards to Flight 427, many of the first responders can still recall the smell from their days of working that crash site. They were in the fields gathering bodies for 12 hours a day; the duration of the exposure was long, and the memories are still vivid for those who responded. The perceived reoccurrence is when people face a tragedy and fear that they will encounter another critical incident, causing them to be in an active state of crisis (Roberts, 2002). In a crisis where an individual has been sexually assaulted, it can be difficult for the person to feel safe leaving home or being alone. It can put someone in a constant state of fear and limit the possibility of using natural coping skills to deal with the situation. The perceived reoccurrence causes disruption in daily routines because the person is living in fear of what might happen next, instead of remaining present in the moment.

Crisis clinicians respond to large and small-scale events with a very specific agenda in order to best stabilize a situation. The actual event is referred to as a *critical incident*, whereas the *crisis* is the response to the event (Everly & Mitchell, 1999; Roberts, 2005). Although many models exist, all are reflective of one another, with very few distinctions. Roberts' (2002) ACT (Assessment, Connecting, Traumatic Stress Reactions) intervention model for acute crisis and trauma treatment ties in many of the major models' steps into a very simple format. Crisis clinicians are responsible for *assessing* (A) immediate needs and threats to public safety. Clinicians need to focus on *connecting* (C) people to supports and social services. Crisis teams that respond to incidents are focused on *traumatic stress reactions* (T) that are inhibiting people from normal functioning (Roberts, 2002; 2005). Each task of assessing, connecting, and exploring traumatic stress reactions has a variety of substeps, but ultimately crisis clinicians use these skills to provide a brief and immediate response to those who are struggling with a crisis. The three steps of assessing, connecting, and exploring trauma reactions are not linear, and some steps will need to be repeated, depending on the incident. In a small-scale crisis with a family who has just lost someone to a completed suicide, the crisis team assesses the family's safety and basic needs but may not be able to move on to connecting people until the family's safety has been established and their basic needs have been met. The team may assess the crisis and feel that safety has been established, but then while connecting people recognize that safety is being compromised and the assessment needs to be repeated. Each crisis is unique, and clinicians need to be able to remain alert and attentive as new concerns and emotions arise throughout the intervention.

The importance of crisis intervention was first introduced in the early 1940s when a Boston nightclub caught fire and 493 people lost their lives. The Boston disaster was one of the worst tragedies in U.S. history, prior to the terrorist attacks of September 11, 2001. Observations of reactions from family members and friends of those who lost their lives showed that many struggled with facing reality and coping with the sudden loss of their loved ones. Medical professionals at the time witnessed denial and delayed reactions of the survivors. Although the literature on the Boston disaster focuses on grief work, there is an aspect of crisis intervention that is relevant for all human tragedy and loss. The literature reflected the importance of not delaying the response to grief because negative outcomes of crisis will develop (Lindemann, 1944). The theory developed by Lindemann allowed people to experience their grief in order to move forward. The theory supports the idea of early intervention, which is at the core of crisis intervention work.

Crisis intervention's main goal is early intervention. Articles have emerged on combat soldiers who experienced stress after witnessing horrible tragedies. The elements of immediacy and proximity were successfully employed to reduce psychiatric morbidity and to increase the rate of return of soldiers to combat following the intervention (Artiss, 1963). Solomon and Benbenishty (1986) also noted that early intervention, along with proximal intervention, were associated with positive outcomes when used with Israeli soldiers experiencing traumatic stress symptoms. Parad and Parad (1968) reviewed over a thousand social work cases and found crisis intervention effective in reducing florid psychiatric complaints and improving coping skills.

We live in a culture where crises and critical incidents are occurring with increasing frequency (Roberts, 2005). The emergence of the diagnosis of Post-Traumatic

Stress Disorder (PTSD) in 1980 (American Psychological Association [APA]), as well as increases in violence and violent crimes (Bureau of Justice Statistics, 2011), indicate a steady rise in the number of crises and critical incidents. The need for crisis intervention responses has increased and has been recognized as a legitimate need in the field of mental health/counseling. Public interest in crisis intervention has increased, most likely due to the rise of impact from acute crisis affecting the general population (Roberts, 2005).

Crisis intervention clinicians commit themselves to working with people in the most critical of situations, from violence and suicidal/homicidal ideation to substance abuse and loss. In addition to increases in the number of natural disasters and violent crimes, there has also been a steady climb in suicide attempts and completion with each passing year. In Pennsylvania alone, 995 people completed suicide in 2010, a 24% increase over the 602 people who took their life in 1999 (Center for Disease Control and Prevention [CDC], 2012). Crisis clinicians work directly with those expressing lethality in the form of suicidal ideation. The increase in the number of suicides reported by the CDC illustrates the need for early intervention to stem a very serious epidemic. It is also important to mention that the numbers reflected by the CDC account only for known suicides; many people take their own life and it is unknown by the public. In the United States, more people die by suicide than by car accident (CDC, 2012). The need for Emergency Medical Services (EMS) is based off the inevitable accidents that occur daily in order to respond and stabilize the individuals in critical situations. Similarly, crisis intervention teams are necessary for early response to stabilize individuals in critical incidents, ranging from Flight 427 to the family impacted by a suicide.

As incidents of suicide or natural disasters occur within society, so does the need for quality crisis intervention to assist individuals in need. Thousands of crisis centers, crisis hotlines, mobile crisis units, and victim support groups have materialized in light of the rise of critical incidents. The unique aspect of 24-hour accessibility of these crisis programs has encouraged consumers to seek out assistance in a brief and immediate manner (Roberts, 1991). Crisis clinicians are working the front lines of direct care with limited information on consumer backgrounds and must provide some resolution upon departure from the crisis scene (Beamish & Hipple, 2007).

A unique population of clinicians within the counseling field performs crisis intervention. Crisis clinicians work with a higher volume of consumers than counselors in private practice or mental health agency settings. The crisis clinicians in Western Pennsylvania are seeing an average of seven consumers a day in vulnerable and intense situations. Another distinction between counseling and crisis intervention is that crisis clinicians must make quick critical decisions while facing numerous obstacles in order to best stabilize a consumer (Everly & Mitchell, 1999; Roberts, 2005). Caplan (1964) suggests that successful crisis intervention should encourage immediacy, proximity, expectancy, and brevity. Crisis intervention seeks to serve consumers immediately, whereas in the counseling profession consumers are waiting to make a decision to go see a counselor. Counselors are often seeing consumers after the initial damage from a traumatic event has already occurred. In contrast, crisis clinicians intervene immediately following a critical incident, oftentimes at the scene where the incident occurred (Myer, 2006). The immediacy of crisis intervention means that early intervention is necessary to reduce the long-term possible negative effects of critical incidents on crisis clinicians.

The expectation of the consumer in the crisis is problem focused. With crisis intervention, the intervention is brief; crisis clinicians do not pick up case loads and follow consumers for any length of time (Everly & Mitchell, 1999). The brevity of crisis intervention increases the urgency for clinicians to ensure that consumers are left with proper support and that all safety assessments are complete prior to the team's departure.

Crisis intervention has very specific functions, which help guide clinicians in intervening with consumers struggling with a critical incident (Roberts, 2005).

The goals of crisis intervention are succinct, and the intervention is delivered over a much shorter time frame than typical therapy. Crisis intervention seeks to stabilize the situation, mitigate symptoms, restore functioning, and facilitate access to a higher level of care (Everly & Flannery, 1999). Crisis clinicians' intentions are to stabilize the situation quickly and efficiently so that the problem solving can begin immediately. Stabilization involves establishing safety and ensuring that all the person's basic needs are being met. A person may be struggling with severe depression and addiction concerns, but he or she may also not have a place to stay for the night; the crisis team needs to work on facilitating shelter before addressing the other two concerns. The literature suggests that, instead of delving into the problems of consumers with long histories, it is necessary in crisis intervention to look to reduce symptoms of stress in the moment (G. Caplan, 1964; Roberts, 2005). The overall goal of crisis intervention is to restore some level of control and stability and move people, if necessary, to a higher level of care or back to normal functioning. Crisis intervention strives to never open up a situation that cannot be closed during that intervention, which is markedly different than what occurs in therapy.



As the field of professional counseling has evolved along with its subspecialties, like crisis intervention, so has the need to implement an intervention within the counseling system to manage and support its professionals. Counselors are expected to handle many significant challenges along with their clients, and supervision of those counselors is an essential step in ensuring that the field maintains its integrity when working with clients.

### **Supervision**

Clinical supervision is a requirement of the mental health field. It's an important intervention regardless of the level of training, because clinicians need to be challenged in order to grow and provide the best care for their clients (Bernard & Goodyear, 2004). Helping professionals to enhance their skills and to continue to develop the competence that is needed to fulfill professional responsibilities is an integral function of counselor supervision (Corey, Corey, Callanan, 2007).

The need for supervision and the recognition of its importance within the counseling field led to the development of the Association of Counselor Education and Supervision (ACES, 1993), which identified specific tasks as the foundation of the role of a supervisor. These tasks include: monitoring the welfare of clients; encouraging compliance with relevant legal, ethical, and professional standards; monitoring clinical performance; and evaluating current performance and potential (ACES, 1993). Thus, supervision is a crucial process designed to ensure the welfare of clients as well as to provide clinicians with professional development and self-care opportunities. The clinical supervisor has an ultimate responsibility to the clients and must ensure that the counselors are assessing clients' needs and oversee the counseling process (Getz, 1999).

Clinical supervision is a multilayered approach to ensuring that all the components identified by ACES are being met.

### **Counselor Educators**

In order to sustain the effective functioning of clinicians in the field of crisis intervention there is a need to review cases, address self-care needs, and discuss clinician reactions to trauma (Gellar, Madsen, & Ohrenstein, 2004). The tasks of case consultation, self-care, and traumatic stress reactions are critical components of the clinical supervision process. Welfel (2002) proposes that effective supervision is essential in the prevention and healing of vicarious trauma. Responsible supervision creates a relationship and an atmosphere that allows clinicians to express fears, concerns, and shortcomings (Bernard & Goodyear, 2004; Welfel, 2002). Counselor educators have an important role in preparing clinicians and supervisors for the field. Crisis clinicians who are susceptible to vicarious trauma and burnout can use the process of supervision as a mechanism to mitigate negative outcomes. Supervision can also provide a teaching component to inform staff about vicarious trauma and the importance of continuing self-care. Counselor educators have a responsibility to educate and support crisis clinicians in seeking guidance from supervisors, as well as providing tools for supervisors to meet the needs of clinicians in crisis work. It is as if people who work in crisis and trauma are often running in the wrong direction. Most people see a fire and run out of the building, but the first responders run into the building towards the fire. The problem is that we don't know how or what supports crisis clinicians.

### **Statement of the Problem**

Critical incidents vary, but typically include crisis teams responding to difficult emotional conditions, gruesome sites, danger, and social order breakdown (Meyers & Wee, 2005). Crisis clinicians operating in a 24/7 environment see numerous clients in these intense moments on a regular and ongoing basis throughout their shift. The ability to manage the variety, frequency, and intensity of these situations is a difficult task in and of itself; ensuring that they remain personally healthy and well is a challenge on another level. In addition to the intensity of crisis intervention, responding to a specific crisis has the potential to trigger the clinician's own unresolved conflicts that can be reactivated by patients or clients who present similar conflicts (Slonim & Hodges, 2000). Although there are interventions in place to assist clinicians in maintaining their self-care—for example, peer debriefing, case consultations, and training in physical and cognitive exercises for relaxation purposes—clinical supervision is seen as a primary source of restorative service and the promotion of resiliency for clinicians (Falvey, 2002; Powell & Brodsky, 2004; Selye, 1976).

Crisis clinicians are paired with a partner when responding to incidents, creating opportunities for natural bonds to occur as they experience a crisis together. Team members can process crisis calls and use each other for informal support. There is also a concept known as the “John Wayne syndrome” that is an independent characteristic that is powerful and prevents crisis workers from assuming a perceived helpless role (Beaton & Murphy, 1995). Many crisis workers employ protective mechanisms such as denial or repression to deceive themselves, as well as others, that they are not being overwhelmed by their work. In many cases it is the clinicians who respond to large-scale disasters that

receive debriefing, but the small-scale crisis seems to go unnoticed unless a clinician vocalizes having a problem or an issue. Unfortunately, there remains a concern that no formal or systematic method has been acknowledged as a means to support continued growth and development and the wellness of professionals in the field of crisis.

Literature exists to support the potential for vicarious trauma of staff working directly with clients in crisis, but little information exists regarding the supervision of clinicians working with daily trauma and crisis (Figley, 2002; Pearlmann, 1999). Other subspecialties of the profession, such as drug and alcohol counseling, have begun to make the case that unique supervision is required for the population served within their discipline (Brodsky & Powell, 2004). There is a need for further understanding about the specific nature of the supervision that is provided in crisis work and how clinicians experience and respond to it. An exploration of how clinicians perceive the supervision that they receive in crisis work is necessary in order to better understand areas that require more attention. The literature does not include a thorough exploration of how or if clinical supervision is a factor in helping clinicians process the potential impact of cases in crisis intervention. This study addressed this problem from the perspective of how crisis clinicians perceive clinical supervision and its role in addressing the negative impacts the work has on them.

National standards require that supervisors have knowledge of all clinicians' cases (Association of State and Provincial Psychology Boards, 2005). Knowledge of all clients in crisis intervention work has proven to be a huge challenge. This lack of knowledge presents a liability issue, because supervisors hold responsibility not only for the clinicians, but for the clinicians' cases as well. The literature informs that the main

responsibility of supervision is to the clients and ensuring that counselors are accurately assessing client needs (Getz, 1999). Similar to drug and alcohol counseling, crisis work needs unique supervision to support the high volume of cases and intensity of the work (Falvey, 2002). The supervision process assists in upholding the ethical boundaries and professionalism of the organization and also serves as a supportive outlet for crisis clinicians in the event of potential secondary or vicarious trauma responses. Crisis clinicians have to manage numerous situations effectively and efficiently. Crisis situations occur every day and require appropriate supervision to build competence, confidence, and ensure that the clients are getting what they need (Beamish & Hipple, 2007). The supervision process should emphasize the value of the emotional bond between the supervisor and the supervisee (Bordin, 1983). The emotional bond developed in supervision can serve as a foundation of trust so that clinicians can feel safe in expressing concerns, both personal and professional, with regard to traumatic reactions. A failure to understand the efficacy in understanding crisis work affects not just the individual clinician, but also the organizations providing these crisis services (Myer, 2006).

### **Purpose of the Study**

The purpose of this study was to explore the lived experience of crisis clinicians in clinical supervision. It was the intention of this research to describe and understand the role that clinical supervision plays in supporting the professional competence and personal well-being of crisis clinicians, from their unique perspective. Knowing that clinical supervision is a best-practice requirement for licensed professional counselors indicates its significance to the field, but understanding the process and experience of

supervision within crisis work is something quite different (Falvey, 2002; Welfel, 2002). Furthermore, this study sought to extract and analyze the perceptions of the supervisees in crisis intervention to determine if and how they experience support and guidance through clinical supervision. This study also sought to understand how, and if, clinical supervision plays a part in supporting professional competence and the personal well-being of crisis clinicians functioning in their role. Given the unique nature and delivery of crisis intervention work, supervision may be experienced in a different manner by crisis clinicians than clinicians working in more traditional subsets of the counseling profession. The goal of this study was to gather rich detail of the lived experience of crisis clinicians, as they perceive supervision.

### **Research Questions**

The questions that drove this study are related to how crisis clinicians experience clinical supervision as a potential support for both professional competence and personal well-being. In creating research questions, the researcher seeks to understand the essence of how people attend to the world, remembering that a person's description is a perception, a form of interpretation (Van Manen, 1990). Using a hermeneutic phenomenological method enables the emergence of the true lived experience of crisis clinicians. A phenomenological approach gives the researcher an opportunity to understand the meaning of the phenomena and through reading, writing, and reflecting transform the experience into a textual expression of its essence (Morse & Richards, 2002).

The driving question of this study overarches several subsidiary questions that appear relevant to the experience of clinical supervision with this population:

1. How do crisis clinicians experience supervision in crisis work?

2. How do clinicians describe their relationship with their supervisor?
3. What does supervision mean to clinicians in crisis work?
4. What is the focus of supervision in crisis work?
5. In what context is supervision received?
6. How do crisis clinicians describe the purpose of supervision?

### **Theoretical Framework**

The theoretical basis for this study is grounded in phenomenology. Phenomenology seeks to describe the lived experience. This study is rooted in Van Manen's hermeneutic phenomenology, which attempts to understand the lived experience through meaning making associated with the identified phenomenon. A phenomenological method enabled an exploration of the lived experience of crisis clinicians, as they perceive clinical supervision in crisis work. Through the work of Max Van Manen, Husserl, and Heidegger, this qualitative study used hermeneutic phenomenology as its methodological foundation.

### **Phenomenology**

Phenomenological researchers believe that a person and his or her world are inextricably linked and seek to explore the essence of meaning of their interaction (Shepris, Young, & Daniels, 2010). This study sought to understand the lived experience through meaning making associated with the identified phenomenon. The phenomenon is the experience of clinical supervision in crisis intervention. Phenomenology provides a descriptive, reflective, interpretive, and engaging mode of inquiry to extract the lived experience of participants (Van Manen, 1990). This methodology is rooted in the works of the German philosophers Husserl and Heidegger, who were interested in understanding the meaning

of people's perceptions. The methodology can be understood through the interaction of four activities: (1) the researcher is encouraged by a certain phenomenon, (2) the researcher examines the experience as it is lived, (3) the researcher identifies the themes of the investigation of the lived experience, and (4) the researcher works to understand each part to the whole of the phenomenon (Van Manen, 1984).

In phenomenology everything is connected. Using Van Manen's phenomenology, this research explored the lived experience of the clinician as well as the phenomenon of supervision in crisis. The methodology allowed the participants of the study to describe and interpret their own experience of the phenomenon. The reality of the lived experience explores the four existentials of lived body (corporeality), lived space (spatiality), lived time (temporality), and lived relation with others (relationality) to help classify the meaning making of the individuals (Van Manen, 1990). Phenomenology motivates this research to understand the meaning of the phenomenon, not the cause.

### **Hermeneutics**

Hermeneutic phenomenology invites the researcher to look more closely at existential dimensions of the lived experience (Guimond-Plourde, 1994). Heidegger (1962) was interested in phenomena that were concealed and believed there was a need for phenomenology to uncover what was hidden underneath. The Heideggerian term *Dasein*, which refers to an aspect of our humanness that has the capability of wondering about its own existence, is the driving force of exploring one's own lived experience (Abas, 2008). *Dasein* is not interested in re-experiencing another experience, but rather grasping one's own experience of the world. The term *hermeneutics* is "an interpretation of *Dasein*'s being" (Heidegger, 1962, pp. 37–38). Hermeneutic methodology allows for a deeper



description as well as interpretation of the lived experience. Hermeneutics encourages a reflection on the experience and the meaning behind it. The hermeneutic process aims at extracting rich data about the lived experience as it happens, not as people conceptualize it. The researcher is the instrument in hermeneutic phenomenology, because all the information flows through the researcher, who already has some experience with the phenomenon. Heidegger identifies hermeneutics as an attempt to understand the phenomena of the world as they are presented to us, an attempt to understand how we go about understanding the world as it is presented to us, and an attempt to understand being itself (Cohen, Kahn, et al., 2000). Although this study was grounded in phenomenology, hermeneutics was the method used to explore the lived experience of supervision of crisis clinicians because the value lies not just in the descriptive (phenomenology), but also in the interpretive (hermeneutics). Hermeneutic phenomenology aims at interpretation of experience through text or other symbolic forms (Van Manen, 1990). The methodology provided the vessel to an exploration of the lived experience of clinical supervision in crisis work.

### **Definitions**

**Crisis:** “A crisis is an acute disruption of psychological homeostasis in which one’s usual coping mechanisms fail and there exists evidence of distress and functional impairment” (Roberts, 2005, p. 331).

**Critical incident:** A critical incident is the stressful event that can lead to someone having a crisis response (Everly & Flannery, 2000).

**Crisis intervention:** A response from a team in order to stabilize a critical incident, mitigate symptoms, and restore functioning to prevent or reduce long-term psychological dysfunction (Everly & Flannery, 1999; Roberts, 2005).

**Psychological trauma:** Damage that can be caused by a traumatic event or a distressing incident. The traumatic event can overwhelm a person's ability to cope or incorporate complicated emotions associated with the event. This type of trauma, when left unattended, to can lead to negative long-term consequences (Everly & Mitchell, 1999; Pearlman & Saakvitin, 1995).

**Vicarious trauma (VT):** A transformation in a trauma worker, therapist, or helper due to an empathic engagement with traumatized consumers reporting their trauma. Clinicians or therapists who work in trauma may experience VT with a disruption in his or her spirituality and/or perceived notion of hope and meaning (McCann & Pearlman, 1990; Saakvitin, 1995).

**Burnout:** A term that refers to long-term exhaustion and a decreased interest in one's work (Maslach, 1997).

**Compassion fatigue (CF):** A term that refers to the impact of empathic immersion in another person's suffering, without pathologizing the clinician (Figley, 2002).

**Secondary traumatic stress (STS):** The direct result of hearing emotionally shocking information from clients (Pearlman & Saakvitne, 1995; Canfield, 2005).

**Clinical supervision:** An intervention performed by a more senior member of the counseling profession that includes an evaluative component, extends over time, and assists in enhancing functioning of clinicians. This intervention monitors client welfare as

well as the personal and professional stability of clinicians within the field of counseling (Bernard & Goodyear, 2004).

**Well-being:** A state where an individual realizes his or her own potential and can cope with the stressors of life. It is a state where an individual is comfortable and able to channel a full experience as well as his or her emotions of the experience into healthy behaviors that still satisfy personal and professional goals (McCullough, 2000).

**Professional competence:** The habitual use of communication, knowledge, clinical reasoning, emotions, and values in daily practice for the benefit of the client or community being served (Epstein, 2002).

### **Summary**

This study, guided by hermeneutic phenomenology, explored the experience of clinical supervision through the lens of clinicians in crisis intervention work. The data gathered from this study help conceptualize the unique intervention of supervision and how it supports clinicians in crisis work. There has been little research conducted to investigate clinical supervision in the eyes of the clinicians working in crisis intervention, yet this is an important part of sustaining stability within the field (Bernard & Goodyear, 2004; Bride, 2004). This study provides insight into how supervision is experienced by the clinicians in crisis intervention that will offer support for the claim that the effective clinical supervision of crisis clinicians is important and necessary.

## Chapter II

### Introduction

*“If you do what you’ve always done, you’ll get what you’ve always gotten.”*

—Anthony Robbins

A review of the literature is necessary to explore what has been done and what is still left to do. Crisis intervention and supervision has garnered a lot of attention over the last decade. Many researchers have shown interest in the potentially negative effects of crisis work, such as vicarious trauma and burnout, and how it impacts the clinician (Figley, 1995; Kanter, 2007; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). This study explored how and if clinical supervision plays a role in supporting clinicians’ professional competence and personal well-being in an attempt to reduce the potential negative effects that accompany crisis intervention. Rather than continuing to examine the existence and progression of compassion fatigue, burnout, or vicarious trauma, this researcher was interested in exploring the experience of clinical supervision as a means to support clinician wellness. This chapter reviews other studies that have explored the facets of vicarious trauma and first responders and addresses the theoretical underpinnings that inform this study. This chapter includes an extensive review of Van Manen’s existentials as a vehicle to conceptualize the lived experience. Finally, this chapter reviews the literature on supervision as an intervention in the counseling profession.

### Negative Outcomes for Clinicians in Crisis

After reviewing the literature it was apparent that many studies had been conducted to determine if vicarious trauma exists for various workers in both the mental health and the

medical fields. One article (Strom-Gottfried & Mowbray, 2006) studied social workers who worked in grief and loss and examined how they experienced professional grief and loss rather than looking at cumulative effects, such as compassion fatigue and burnout. The article highlighted the difficulty in being with clients who are at the end of life and how that experience may impact the workers. The article outlined the stages of grief and loss as the social worker may experience them and suggested possible ways that professionals can seek support. Strom-Gottfried and Mowbray (2006) made recommendations for formal debriefing in the form of the Critical Incident and Stress Debriefing (CISD), as well as having agencies train workers for signs of compassion fatigue.

Researchers Shuster and Galea (2002) conducted separate studies after the September 11 attacks, surveying helpers' stress levels after their involvement with the event. According to both studies, reports of PTSD and secondary traumatic symptoms were confirmed. The articles stressed the importance of sharing trauma with teammates in order to process difficult parts of the event. Trippany and Kress (2004) discussed inevitable vicarious trauma for workers who were first responders in any capacity and suggested peer supervision, education, and training, as well as encouraging personal coping skills, to help support staff.

Kanter (2007) addressed compassion fatigue and secondary traumatization in the mental health field as barriers for counselors sustaining in their jobs. The article highlighted the concerning issue of countertransference with clients and stated that clinical supervision and professional consultation may provide helpful outlets to support professionals. Others have identified that a skilled clinical supervisor might be able to

assist in extricating the clinician with minimal damage to the client and provide an opportunity for professional growth for the counselor (Figley, 2005; Kanter, 2007).

One study used path analysis to determine the existence of vicarious trauma (VT) in clinicians who were exposed to childhood trauma and identified several contributing factors that create vicarious and secondary trauma in professionals (Williams, Helm, & Clemens, 2012). The quantitative study indicated that among wellness activities and managing a high workload, supervision emerged as a potential helpful intervention to avoid professional isolation and provide support to clinicians. The article by Williams, Helm, and Clemens (2012) illuminated an important aspect of supporting clinicians by addressing supervision and the supervisory relationship as a potential benefit to help clinicians in both their professional and personal well-being. The literature suggests that, like educators, supervisors can promote wellness as well as self-care in staff (Somner, 2008).

Much of the previous work on crisis clinicians and first responders in regards to vicarious trauma, secondary trauma, compassion fatigue, and burnout have laid the groundwork for this study's attempt to describe ways to support crisis clinicians. Additionally, the research begins to scratch the surface of the significance and potential of supervision as a vehicle to support crisis clinicians and for this study's examination of the role that clinical supervision plays in protecting crisis clinicians from the negative outcomes from doing crisis work. This research focused on how clinicians perceive clinical supervision as a means to support and promote professional and personal well-being.

## **The Impact of Crisis Work**

The crisis clinician's responsibility is to aid in supporting and stabilizing people in the moment of a crisis. The increase in the number of large-scale crises has raised awareness of the potential psychological effects of traumatic events (Hambleton, Watson, Norris, & Pfefferbaum, 2005; Norris, Friedman, & Watson, 2002). Mental health services, including crisis intervention, are integral components in responding to disasters both large and small. Secondary or vicarious trauma experienced by those first responders has received less attention (Bride, 2007; Figley, 2002). Crisis teams are exposed to traumatic events on a daily basis. Although these events range in intensity and scale, each has the capacity to evoke strong reactions by the clinicians. Additionally, crisis clinicians may need to continue to respond to events after the initial event to monitor and support potential psychological impact (FEMA, 2006). An ongoing response by a crisis team increases the exposure to the event and the people traumatized by the event. As previously identified by Roberts (2002), spatial dimension and subjective time clock increase the risk of potential impact and psychological repercussions. The crisis team's increased exposure places team members at risk with regards to the categories of spatial dimension and subjective time clock, because they will respond to events on the scene of the incident and spend many hours with victims and witnesses. Many clinicians are used to providing support and hearing people's stories, but crisis clinicians are performing these roles in addition to many others, including monitoring and assessment, connecting with support, setting up shelters, and providing case management, while on the scene of a crisis. Performing these roles in difficult environments under pressure to work quickly and effectively can create unusual circumstances and increase the risk of potential

secondary traumatic stress or vicarious trauma (Figley, 2002). Secondary traumatic stress is the direct result of hearing emotionally intense and shocking stories from clients (Figley, 1995).

Although working in crisis intervention does not guarantee that clinicians will experience vicarious or secondary trauma, the intensity, frequency, and variety of the experience can increase the likelihood of an emotional response from crisis clinicians. This impact can greatly affect the ability of crisis clinicians to do their work. Secondary or vicarious trauma can impair a crisis clinician both personally and professionally. Experiencing traumatic stress can shift cognitive and emotional states, including the clinician's sense of meaning, personal safety, trust, and spiritual beliefs (Pearlman, 1999). Kammerer and Mazelis (2006) suggest that once we experience a traumatic event, the way we view ourselves and the world around us changes.

If you ask a crisis team what the most important thing to be aware of on a crisis call is, regardless of the size of the event, they will answer "safety." The crisis team must feel safe and ensure the safety of others before any intervention can happen. If a traumatic event changes the way a clinician views safety, this can pose a serious threat to the safety of the team and the individuals being served. Oftentimes clinicians become complacent because they have witnessed so many crises, jeopardizing the safety of others. The first time you do something there is fear, but the fear decreases the more familiar you become with the situation. Similarly, crisis clinicians may lose the momentum of fear, which could greatly impact the intervention. Senses need to be heightened, and a crisis clinician must be hypervigilant at all times. However, clinicians who have experienced trauma may have decreased hypervigilance and sensitivity. Aside from safety, crisis



clinicians need to have the confidence to support and stabilize the situation. When people go without sleep, they may not be as alert and ready to react as they are when they are rested. Crisis clinicians who experience trauma without getting support may feel an emotional exhaustion that can diminish their confidence and ability to react and make decisions, which are vital in a crisis intervention.

The literature suggests that it would be best for supervision and evaluation to be separate in an organization because of concerns that evaluation might prevent clinicians from bringing up issues (Pearlman & Saakvitne, 1995; Regehr & Cadell, 1999; Rosenbloom et al., 1995). Many people spend their lives avoiding trauma and crisis, but crisis intervention teams purposely put themselves in those situations (Harris, 1995).

### **Clinical Supervision in Crisis Work**

Few activities within counseling are as important as clinical supervision (Bernard, 1998). Supervision is an essential component of the counseling profession because it fosters clinicians' growth and development.

Supervision is a multilayered, unique intervention, and no matter the level of the clinician, supervision can serve to challenge, guide, and provide support. Supervision can look very different depending on the supervisor, the clinician, the population of clients served, and the organization. Regardless of the different deliveries, the message is still the same in that supervisors serve as gatekeepers for the profession. Bernard and Goodyear (2004) inform:

Supervision is an intervention provided by a more senior member of a profession to a more junior member or members of the same profession.

This relationship is evaluative, extends over time, and has the

simultaneous purposes of enhancing the professional functioning of the more junior person (s), monitoring the quality of professional services offered to the clients that she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession. (p. 8)

Clinical supervision has many components in order to best meet the needs of the clinician while upholding professional ethics and standards. The Association for Counselor Education and Supervision (ACES, 1993) identifies specific supervisor tasks, including encouraging compliance with ethical and legal standards of practice, monitoring client welfare, evaluating performance, and monitoring clinical performance. Clinical supervisors are responsible for the clinician's and the clients' welfare. In crisis intervention work, the volume of cases and interactions are so high that clinical supervision can be a monumental task. Additionally, clinical supervisors have a responsibility to support both professional and personal well-being to ensure that the clinicians have the necessary support to do work with clients. If the clinical supervisor is responsible for client welfare through the clinicians, then issues of vicarious trauma or compassion fatigue can be concerning, because it can directly impact the clients. Supervision incorporates a clinical and a personal piece that is central to clinician development.

Clinical supervisors tend to the clinical aspects of case conceptualization, treatment planning, intervention, and safeguarding of clients (Bernard & Goodyear, 2004). Clinical supervisors support the personal aspects for clinicians by building confidence in clinicians, providing feedback, helping clinicians become aware of their strengths and limitations, guiding them on managing emotions that can emerge with

clients, as well as assisting with workload management and counselor self-care (Bernard & Goodyear, 2004). It can be a lot to attend to for a supervisor, but lack of supervision impacts the entire system.

The counseling profession has acknowledged the importance of recognizing and intervening when counselors may be providing substandard care (American Mental Health Counselors Association, 2000; Anderson, 1992). Unfortunately, supervision has been a reactive intervention instead of a proactive one to help clinicians manage workplace stress, vicarious trauma, compassion fatigue, and overwhelming caseloads. Due to high turnover rates of direct care workers in trauma, which can lead to burnout, supervision is an ethical imperative (Jones et al., 2007). Several models of supervision have been explored in the literature, and the importance of this intervention is a known fact. Still, little is known about the experience of supervision, particularly in crisis intervention, and more research is needed to understand it from the perspective of both counselor and supervisor in various settings (Pelling, 2008). In crisis intervention, the clinician's own unresolved conflicts could potentially be reactivated by clients with similar issues, and these emotions can be monitored and managed through clinical supervision (Slonim & Hodges, 2004).

Although supervision is a requirement for the profession, it is an essential support for crisis clinicians because it may play an even more critical role in crisis intervention. Clinicians working in crisis intervention not only need to experience professional support in the delivery of clinical supervision, but they also need personal support to counter the negative influences of the acute and intense nature of their work (Bernard & Goodyear, 2004; Gladding & Newsome, 2010). Increased access to effective and convenient support

could lead to enhanced stability within the clinician as well as the field of crisis intervention.

Crises can leave people struggling to maintain normal functioning. The clinicians who work in crisis intervention are responding to various critical incidents with consumers who they are meeting for the first time, which can be overwhelming. Crisis clinicians need to access many different skills at a moment's notice. It is imperative that clinicians working in crisis intervention are afforded the appropriate opportunity to fine-tune those skills through clinical supervision. In addition to enhancing skills, clinicians need an outlet in the form of supportive clinical supervision to help increase sustainability within the field of crisis intervention. Supervisors have an ethical responsibility to alert clinicians to remain mindful of self-care so that they are at their best when attempting to take care of clients. The supervisory relationship is an essential component to appropriately addressing the needs of consumers and the professional and personal needs of clinicians (Pistole & Fitch, 2008). The importance of supervision is recognized in the literature, and it is recommended that policies be in place to ensure clinical supervision and to manage various crises that may arise within an organization (Bernard & Goodyear, 2004; Falvy, 2002).

Although there is not a sufficient amount of literature on clinical supervision in crisis intervention, an abundant amount of literature is available on stress in crisis caregivers. Clinicians put themselves at risk of crisis when they do not seek support (Roberts, 2005). In mental health agencies and counseling organizations, supervisors tend to their counselors when consumers are in crisis, but little information exists as to the supervisory role when the consumers are *constantly* in crisis.

From the Boston fire to Flight 427 to the family who just lost a father and husband to a completed suicide, all crises can leave people struggling to maintain normal functioning. People relying on crisis intervention teams are sharing personal and intense emotions about the critical incident they have experienced. The crisis clinicians are typically responding to the crisis event, putting them in jeopardy of the spatial dimension, subjective time clock, and perceived reoccurrence factors that Roberts (2002) identified as three critical areas of impact. Crisis clinicians who bear witness to the destructive effects of their clients' trauma will be affected by it (Gellar, Madsen, & Ohrenstein, 2004). Empathy is central in the counseling field, and it is particularly important in crisis intervention. Ironically, it is the crisis clinician's empathy and willingness to share the client's experienced emotional distress that exposes the clinician to the possibility of compassion fatigue or vicarious trauma (McCann & Pearlman, 1990). Many contributors to crisis intervention and disaster relief work use the metaphor of the oxygen mask on the airplane and the significance of putting on your own oxygen mask before assisting someone else with theirs (Everly & Mitchell, 1999; Roberts, 2002). In the field of crisis intervention, clinicians tend to the event, and the victims do not pay attention to their own responses. It is not uncommon that crisis clinicians are with clients at a crucial life stage that evokes intense feelings of regret, anger, sadness, and hopelessness in clinicians (Strom-Gottfried & Mowbray, 2006). However, it is rare for clinicians to tend to themselves, because they are expected to respond to crisis events in a timely manner and to be fully present once on scene. Traumatic events can change the way the self and the world are experienced (Figley, 2002; Kammerer & Mazelis, 2006). If traumatic events change a clinician's perception, then there is a danger that the clinician may not attend to

his or her needs, which may have a negative impact on the clinician's wellness and ability to work with clients in the future.

### **Vicarious Trauma**

In the last decade, copious amounts of research have emerged on vicarious trauma (VT) and its impact on therapists. Most of the existing knowledge on VT focuses on the potential long-term effects as well as areas that most likely induce traumatization in professionals (Carbonell & Figley, 1996; McCann & Pearlman, 1995). Researchers have been interested in comparing VT to countertransference and how they can negatively impact work with clients (McCann & Pearlman, 1995). This research has paved the way for the helping profession to take a closer look at how counselors are taken care of.

VT refers to disruptions of the counselor's internal experience in reaction to repeated exposure to traumatic information shared by clients, such as that involving rape, violence, abuse, and death (Herman, 1997; Pearlman & Madan, 1995). The disruptions range in severity and frequency for clinicians, but oftentimes can encompass symptoms of post-traumatic stress disorder (PTSD). Similar to primary trauma reactions, VT can disturb a clinician's ability to think clearly and manage emotions in order to feel effective in his or her work. VT can deplete a clinician's ability to maintain hope in certain situations, and hope is a vital component in any crisis intervention. A crisis clinician experiencing vicarious trauma may become defensive and potentially withdraw from supports (Figley, 1995; Pearlman & Saakvitne, 1995). Additionally, clinicians who struggle with VT may begin to doubt themselves and their ability to manage clients. The impact of VT, when left unacknowledged, can create ethical concerns, because clinicians may become less accessible emotionally or lose focus (Saakvitne & Pearlman, 1996). The

theoretical model of how trauma and burnout impact consumers is a worthwhile chart for supervisors and clinicians alike to continue monitoring themselves and staff (Appendix B).

The literature has explored the risk of VT in certain populations. Counselors who work with childhood sexual abuse have to see and hear complex emotional stories that can take a toll on the professional. Research is limited in the areas of crisis intervention and first responders and whether supervision can help buffer VT to sustain clinicians. Crisis intervention is a unique subset of the counseling field that forces clinicians to face repeated trauma and disaster on both large and small scales on a daily basis. The repeated exposure causes a shift in thinking and how clinicians perceive themselves in the world (Trippany & Kress, 2004). No studies to date have examined VT, secondary traumatic stress, compassion fatigue, or burnout and how or if a supervisory relationship can help clinicians process those complex emotions (Pearman & Saakvitne, 1995). Given that the impact of VT has been described as an occupational hazard, it seems crucial that an exploration be completed on crisis clinicians' lived experience, as they perceive support in the form of clinical supervision.

### **Burnout**

The counseling field has a high rate of turnover that can be directly linked to clinician burnout. The helping field is a demanding one, and it often takes a toll on the professionals working within its domains. Working with clients and doing intense emotional work can increase the potential for the vicarious trauma, secondary traumatic stress, and compassion fatigue that can lead to burnout. Clinicians working in crisis intervention have a heightened risk of burnout due to the constant exposure to complex

and sometimes tragic circumstances. *Burnout* is a psychological term referring to long-term exhaustion and diminished interest in work (Maslach & Leiter, 1997). A measurement of burnout was produced in the early 1970s to determine the effects of emotional exhaustion and a reduced sense of personal accomplishment (Maslach & Leiter, 1997). This measurement scale for burnout has become a standard, and it involves a three-dimensional description of exhaustion, inefficacy, and cynicism. Maslach and Leiter identified engagement as the antithesis of burnout because it revolves around energy, efficacy, and involvement, which are the opposite of exhaustion, inefficacy, and cynicism. Burnout is inevitable and has caught the appropriate attention of working professionals in the counselor education field. Burnout prevention has become a growing interest for researchers and direct care workers alike. The only true prevention that coincides with energy, efficacy, and involvement is organizational change and education (Maslach, Schaufeli, & Leiter, 2001; Sanders, 2013). Herbert Freudenberger (1947), who identified 12 phases of the burnout process that clinicians may experience, first coined the term *burnout*. The phases of burnout are relevant for review in this study, because they are potential indicators that could be addressed in clinical supervision to ensure that clinicians have a solid foundation when beginning this intense work. The 12 phases help conceptualize the process of burnout and how it may impact clinicians in the helping profession.

### **The Compulsion to Prove Oneself**

When clinicians are first starting out in the field, they are often eager to prove their abilities and knowledge. Oftentimes the desire to demonstrate their competence can turn into a compulsion. More often than not, in crisis intervention clinicians learn by fire. A



crisis clinician is often trained while on crisis calls in order to gain exposure and firsthand experience. Many times in those critical moments newer clinicians want to be a part of the team and worthy of contributing something valuable to the intervention. In this respect, it is a disservice to new clinicians, because they may want to appear to be at a high level of understanding when in reality they are struggling to conceptualize and intervene in crisis events.

### **Working Harder**

It can be a challenge to fit into any new organization. In crisis intervention work, bonds form among the clinicians because they respond to many traumatic situations as a team. Clinicians learn to depend on one another in difficult moments, and a new clinician works hard to fit in along with them. This phase can make clinicians narrow their focus and become consumed with doing everything by themselves in order to continue proving their capabilities. In this phase, new clinicians may feel that by working hard on their own they are demonstrating that they are capable and don't need a lot of assistance, hoping that this will help them fit in with others. Clinicians strive to prove their value in hopes of being considered a contributing member of the team.

### **Neglecting Their Needs**

New clinicians dedicate their time to proving themselves and working hard in order to do it. Working hard at proving that they can get the job done and done well leaves little time for anything else. Oftentimes clinicians neglect family, friends, and loved ones because all of their attention is on the work. Doing the work and ensuring that they are doing it well requires a lot of energy that the new clinicians cannot then use to tend to their own needs. Those in the helping profession recognize the need for others to care for

themselves, but often struggle to take this advice and apply it to their own lives. The issue with neglecting needs is that without an “off” button, the clinician is always a clinician and struggles in setting that role aside to remain present in day-to-day activities outside of work.

### **Displacement of Conflicts**

In this phase, the clinician’s work begins to suffer because of all the energy being expended in fitting in and excelling at the job. During this phase, clinicians are typically unable to recognize that their work is suffering. Oftentimes physical symptoms of stress and overwork emerge. When a person dedicates all of his or her time to only one project, other areas of life may start to suffer from getting less attention.

### **Revision of Values**

In this phase, clinicians begin to isolate themselves from others. Clinicians will tend to avoid conflicts because they have no energy left to confront challenges directly.

Oftentimes, clinicians may readjust their value system and decrease the amount of time spent with family or friends and only focus on work. This phase can be a dangerous place for clinicians and clients, because any revision in values due to exhaustion leads to inconsistency that could impact the intervention. This phase can create an emotional bluntness in clinicians that can greatly impact their work and life.

### **Denial of Emerging Problems**

Clinicians continue to withdraw in this phase, particularly in the social realm. It can become uncomfortable for them to go out with friends or socialize. Clinicians tend to use the excuse of work demands and time pressure as reasons why they can’t go out and enjoy social company. Work–life balance creates more stability and typically more

success for people to perform better at work and home. We feel better when there is cohesion with these two major areas, and anytime we deny potential problems because we are drained from one of those aspects we are putting ourselves and the people around us in jeopardy.

### **Withdrawal**

During this phase, clinicians draw away from their social circle and tend to be more introverted than usual. They isolate themselves because others don't understand their job pressures and responsibilities. Clinicians can lose hope in this phase and struggle with having direction. The withdrawal phase in burnout is significant, because according to the American Time Use study (2012) we spend more time at work than doing any other activity, based on a 40-hour workweek and not including holidays. Because work is such a large part of our lives, withdrawing from the other aspects leaves us stuck in work mode all the time.

### **Obvious Behavioral Changes**

At this point in the burnout process, clinicians begin receiving feedback from family and friends that something has changed within them. Others take notice that the clinician seems more tired, more sarcastic, and more isolated.

### **Depersonalization**

Clinicians struggle with their own self-worth and value in this phase. They may no longer see themselves as having anything worthwhile to contribute. Clinicians will lose track of personal care needs and focus on the present, unable to see direction in the future tense.

### **Inner Emptiness**

Clinicians tend to feel they have no value and struggle with self-esteem issues in this

phase. Typically, clinicians struggling with inner emptiness might lean on drugs and alcohol or other dangerous activities to feel some adrenaline. Clinicians might engage in risk-taking behaviors to offset the emptiness they feel inside.

### **Depression**

Burnout can include depression where clinicians feel loss of hope, exhaustion, and lack of motivation to change their situation or circumstances. Clinicians struggle with the meaning and purpose of life and their life's work.

### **Burnout Syndrome**

Clinicians collapse both physically and mentally in this final phase. If depression is present, suicidal ideation could become a concern. This phase is when clinicians should seek medical help.

### **Compassion Fatigue**

The counseling profession is a helping field. Clinicians aim to demonstrate empathy and compassion towards clients in order to foster a healthy rapport so that clients can then feel comfortable sharing their story. Without compassion or empathy the interactions between clinicians and clients are empty. The compassion and empathy required in counseling sessions aid in building rapport, which has been proven to improve therapy outcomes (Frieswyk et al., 1986; Leach, 2005; Pedneault, 2014). Every day the news delivers compelling, tragic stories. Most of the news we hear is bad and can evoke strong emotions. Several television programs have been developed for the purpose of sharing details of the tragic stories that occur every day. If we sat and watched every newscast or every special that reported on death, violence, and people suffering, we could easily become overwhelmed with our own grief and sadness for the people in those stories.

However, television viewers have the ability to turn the news off; there is a moment where we can make a decision that we need a break or that we are overwhelmed and need to do something other than watch these sad stories play out in front of us. In crisis intervention, hearing sad and unfortunate stories or seeing critical events and disasters becomes the norm, and clinicians cannot simply turn it off or disengage. Clinicians have to remain engaged with the disaster until relief comes or a decision has been made for the victims or the witnesses to find other support, thus exposing clinicians to the event for long periods of time. Figley (1995) suggests that the term *compassion fatigue* captures the impact of empathetic immersion in someone else's suffering. Compassion fatigue (CF) can cause clinicians to experience symptoms that parallel PTSD, such as re-experiencing the trauma, hyperarousal, or avoidance (Figley, 1995, 2002). Clinicians experience CF in a similar fashion as vicarious trauma, because it can express itself in clinicians' self-identity. CF can result in an emotional overload for clinicians, without pathology, and it can present a danger to the clients that work with clinicians who are affected by it. CF can cause a clinician to experience a reduced level of interest in empathy from knowing about a traumatic event from another individual (Figley, 2002). The reduced level of interest that occurs with CF, if left unnoticed by the clinician or supervisor, can greatly impact the client, the intervention, and the clinician's quality of life (Appendix C).

Crisis clinicians face repeated exposure to difficult and complex situations on an almost daily basis. Every crisis is unique, and certain aspects can touch us in different ways. Clinicians may experience symptoms from the trauma they encountered, leading to vicarious trauma, a component of compassion fatigue. Clinicians may experience a

numbing sensation to traumas after witnessing and hearing about so many within their work, decreasing their ability to remain present, empathetic, and compassionate with clients (Figley, 1995; Trippany & Kress, 2004).

Although compassion fatigue and vicarious trauma can be paralyzing to clinicians in the field, recommendations have been offered to assist clinicians in those circumstances. Some of the strategies that have been suggested are use of social supports, self-care strategies, conflict resolution techniques, and further development of caregiving skills (Boscarino, Adams, & Figley, 2010). Both compassion fatigue and vicarious trauma can be enhanced due to other factors outside of the profession. Figley (1995) identified that family stressors or a history of personal trauma can increase the risk, length, and intensity of vicarious trauma and compassion fatigue.

Compassion fatigue and vicarious trauma result from repeated exposure, but many clinicians would not identify themselves as “traumatized.” Clinicians’ lack of acknowledgment of trauma could be because they have not been educated on the signs and symptoms or because the stress and anxiety they experience after crisis calls have not disrupted their daily routines. Part of the education process is having professionals within the system of mental health recognize and acknowledge potential signs and symptoms of VT or CF. A professional quality-of-life scale has been developed to assess the presence of potential CF symptoms so that clinicians can heighten their sense of self-awareness around possible impact from working in the field.

### **Compassion Satisfaction**

Although much of the literature focuses on potential negative impacts, such as vicarious trauma and compassion fatigue, the opposite reactions are also possible and do occur.

Compassion satisfaction (CS) is when the clinician experiences the good aspects that are inevitable in the helping profession (Appendix B). In crisis intervention, seeing people in their most vulnerable moment can be profound and difficult, but there are moments when people rise above the circumstances and thrive. Crisis clinicians have a unique opportunity to work with people in critical moments and support clients in overcoming obstacles. Clinicians can feel a sense of pride and relief that the situation was handled well. Additionally, clinicians can hear traumatic stories and feel value in their work in helping clients out of those situations. CS can provide a buffer for clinicians doing work in trauma and counteract against the negative effects of compassion fatigue (Tyson, 2007). The PROQOL professional of quality-of-life scale (2009) is also accessible for both compassion satisfaction and compassion fatigue (Appendix C). It is important to recognize both sides of impact for crisis clinicians. The PROQOL scale can be a useful tool for professionals to conduct a self-assessment or for leadership to provide to staff in order to get a better handle on the pulse of the organization. In addition to the scale, theoretical models of compassion satisfaction and compassion fatigue have been developed to add a visual aid to the flow of work and impact that may be experienced by clinicians. Stamm (2010) developed the models to conceptualize potential triggers for compassion fatigue and compassion satisfaction as well as any secondary traumatic responses that could emerge in clinical work. Self-assessments exist to aide clinicians in monitoring and managing their own individual level of compassion satisfaction so they can obtain a better idea of when to ask for further support (Appendix D). Many times in the helping field clinicians are juggling a heavy caseload, repetitive and overwhelming paperwork, and complex emotional situations, which can be a recipe for impact, both

positive and negative.

### **Vicarious Resilience**

Similar to the concept of compassion satisfaction is vicarious resilience. Many times we remain focused on the negative impacts, but people are resilient. Disasters occur and tragedies strike, and there are people who take on those critical events and feel gratitude for the opportunity to help. Vicarious resilience is the process of adapting well in the face of crisis, adversity, or trauma (Saakvitne & Pearlman, 1996). There are steps that can assist in this “bouncing back” process of vicarious resilience to help clinicians in the helping profession. The steps suggest that clinicians should be proactive in managing their mental wellness in order to enhance natural resiliency. Another potential support to increase chances of vicarious resilience is systemic support from the organization and acknowledgment of the clinician’s successes and value within the agency.

### **Developing Self-Awareness**

Carl Jung (1958) said, “Everything that irritates us about others can lead us to an understanding of ourselves.” Self-awareness is the skill most actively developed in the counseling profession during a master’s program. Countless self-assessments are done across graduate school programs to instill in developing counselors the extreme importance of self-awareness. Once in the field, self-awareness becomes an afterthought as work takes precedence. It is important that clinicians know their strengths and limitations and how they play a part in their interactions with clients. Another important aspect of self-awareness for clinicians is remembering and reinvesting in their original motivation to be in the field. The most essential aspect of self-awareness is recognizing when to ask for help, which may be the most challenging task for clinicians who work to



help others. Tools exist to help support clinicians and supervisors in the field to determine self-care and identify areas for improvement (Appendix B, Appendix B-1).

### **Maintaining Hope**

Maintaining hope sounds so simple, but in trying times hope can be hard to see. Hope hides in hearing and seeing the negative side of people and the dark side of life, and it can be difficult for clinicians to hold onto it throughout their work. Without hope, clinicians may lack direction and purpose when working with clients. There are times when clinicians may be exposed to a scenario that exposes their vulnerability as humans, but they are still expected to remain in their clinician role and tend to the people and the situation. Hope has been a cornerstone in the helping field for many years, with even Freud (1901) acknowledging, “Out of your vulnerabilities will come your strength.” Clinicians often hear the same stories over and over again and can become jaded that things will ever change or be better. It’s important for clinicians to look for the good in certain situations and try to focus on things that can be changed rather than what cannot. Hope is something clinicians try to instill in their clients, with the aspiration that clients will develop the drive and belief that they can make their situation better.

### **Practice Healthy Coping**

Part of healthy coping is remaining aware of the reality of the work being performed. Clinicians should accept change as a constant and engage in realistic problem solving. Maintaining positive and healthy relationships at work and outside of work are also beneficial for clinicians to practice healthy coping. Another important element of healthy coping is to let go of the small things and to not lose sight of the big picture and larger goals.

## **Creating Strong Relationships**

It is important to sustain relationships and connections inside and outside of work. Those relationships provide a sense of purpose and value outside of one's job duties and can provide emotional relief. It is also important for clinicians to build connections and collaborate at work in order to have access to support from people who understand the job.

## **Remembering the Big Picture**

Clinicians who can remain focused on the big picture and not get lost in the frustrating details tend to have an increased level of resiliency. Clinicians who remember what motivated them to do the work have an easier time finding value in challenging moments. Bringing attention to resilience and vicarious resilience can strengthen it. These steps are important in building and maintaining vicarious resiliency, which can help clinicians to feel better personally and professionally and sustain in the field.

## **Self-Care**

*“If your compassion does not include yourself, then it is incomplete.”*

—The Buddha

Towards the end of most counselor training sessions or lectures is a reminder on the importance of maintaining self-care. Although it may seem as if it is always an afterthought, most helping professional proclaim that self-care is perhaps the most important aspect of the helping profession. It is the pink elephant in the room—everyone knows it's there and important, but never quite ready to acknowledge it. Clinicians may be reluctant to acknowledge it for fear of bringing to the forefront their own limitations and internal struggles that they work so hard to keep at bay. The old adage that you can

never truly help someone else until you have helped yourself rings true, and yet the profession still struggles to focus on it. The analogy of the airline attendant telling passengers to put on their own oxygen masks before assisting others is quite relevant to the helping profession. Logically, we know that it makes sense because we cannot tend to someone else if we can't breathe ourselves, and yet it is so challenging for most of us to proactively practice self-care. The literature suggests that clinicians need to be practicing responsible selfishness through self-care by becoming involved in activities, actually taking a lunch break, leaving work behind until the next day, or saying no to preserve some energy (Welsh, 1999). The steps identified in vicarious resilience speak to self-care and are an important component to being a long-lasting, effective clinician. Part of the self-care piece is something that should be fostered and reinforced in clinical supervision to help sustain clinicians. Permission, guidance, and role modeling can serve as effective methods to support and promote self-care in clinicians.

Many self-care assessments are available that can help clinicians and supervisors alike in monitoring and identifying areas of concern regarding self-care. Lack of self-care can lead to burnout, which leaves clinicians more susceptible to vicarious trauma and compassion fatigue. It is in our already vulnerable moments that we leave ourselves open to becoming overwhelmed and emotionally drained. Norton (1996) provided a self-care survey that identifies physical and psychological self-care to help clinicians recognize potential areas of concern (Appendix E).

### **Theoretical Perspectives**

This study was driven by Van Manen's hermeneutic phenomenology using Colaizzi's method of inquiry (Appendix A) to extract the lived experience of clinicians, as they

perceive clinical supervision in crisis intervention. Several theories inspired and motivated the use of phenomenology in this study. The theories grounded the methodology and provided a foundation to enhance the understanding of the multiple components of the study.

A discussion of social constructivism and constructivist self-development theory follows; their integration into the methodology of hermeneutic phenomenology is described in Chapter 3. The purpose of a phenomenological study is to explore the meaning and essence of the lived experience (Johnson & Christensen, 2004). Part of the meaning and essence comes from participants' description and meaning making of the phenomena of interest, in this study clinical supervision in crisis intervention. The theories reviewed in this chapter align with the methodology by providing frames of reference to understand the perspective of crisis clinicians' experience of clinical supervision.

### **Social Constructivism**

Many theories have been formulated that address the ways people learn and adapt to their environments. Jean Piaget played a major role in studying learning theory for children as they grow and develop. Lev Vygotsky expanded on Piaget's learning theory and put forth the concept of social constructivism. Social constructivism emphasizes the importance of culture and understanding what occurs in context in order to build knowledge (Vygotsky, 1978). The theory addresses the significance of social interaction in the learning process, which coincides with the phenomenological process of interviewing participants to learn more about their experience of the phenomena. Social constructivism is grounded in three main principles, or factors, that contribute to the learning process: reality, knowledge, and

learning (Kukla, 2000; Prat & Floden, 1994). Social constructivists believe that people construct reality based on their experience and social interactions; reality does not exist prior to social invention (Kukla, 2000; McMahon, 1997). Clinical supervision has been a long-studied intervention, but to really know and understand the experience and the concept it is necessary to engage with the clinicians and discuss the experience. Similarly, knowledge and learning are social processes and cannot be fostered or grow without social interaction (Crotty, 1998; Kukla, 2000). Knowledge and learning are not passive processes; this study was qualitative, requiring engagement and interaction in order to fully learn more about the concepts and lived experience of the phenomenon of interest.

Social constructivism addresses the interaction between social and physical context as essential to fully learn concepts (Vygotsky, 1978). Similarly, phenomenological research mirrors the conceptualization of the theory because the researcher ultimately immerses himself or herself in the culture to uncover the lived experience. In this study, the researcher used social constructivism to make sense of the experiences and descriptions provided by participants. Phenomenology encouraged the researcher to not just simply observe, but to engage with the participants to build questions in order to construct understanding and meaning. The theory of social constructivism was relevant not only for the researcher to learn from the participants, but also for the participants to learn from the process of engaging with the researcher and other participants. The participants in this study talking about their experiences and understanding of how and if clinical supervision was a supportive intervention provided them an outlet to really identify and process a daily activity.

Socio-constructivist learning has a number of different functions, including reflection

and exchange, scaffolding and storyboarding, facilitation and content, monitoring and assessment, production and investigation, and psychological support and community (Kauppi, 1995; Manninen, 2000). The first two functions of reflection and exchange and scaffolding and storyboarding identified through social constructivism reflect the process in this hermeneutic study of exploring lived experience and meaning. The exchanges that are identified within this theory are the very interactions performed in hermeneutic phenomenological methodology and align with Colaizzi's method of inquiry performed by this researcher for the purpose of this study. The first interaction noted of reflection and exchange was very much a part of the method of this study. The researcher interacted with the participants and reflected on themes and central concerns and brought it back to group of individuals to validate the information gathered. It was in the reflection that categories were developed and then clarified with the participants in order to ensure the validity of the descriptions and meanings. The reflection and exchange afforded the participants an opportunity to not only validate themes, but also to hear back their own experiences from another perspective. Additionally, scaffolding and storyboarding were used to help create a narrative of the lived experience for crisis clinicians in order to learn more about the phenomena and help make meaning. The other functions of social constructivism highlighted coincide with the phenomenological process and helped ground the method in terms of learning and making sense of the phenomena of interest.

### **Constructivist Self-Development**

The idea of trauma has been of great interest to many professionals and researchers within the field of counselor education. The constructivist self-development theory (CSDT) was developed based on a trauma framework as a model for working with

survivors of childhood abuse (Saakvitne, 2000). The CSDT model emphasizes that symptoms are adaptations and that there is healing power in the relationship between health professionals and survivors of trauma (Saakvitne & Pearlman, 1996; Williams & Sommer, 1995). The CSDT model stresses connections so that the survivors can develop trust with the counselor; this model can be reflective in the supervisory process as well. It would seem important for clinicians who experience some level of secondary trauma or impact to have a relationship that enables them to feel safe enough to express concerns and frustrations while managing other cases. The CSDT model was developed by social constructivists who believe that trauma shapes how people construct their reality and can drastically change their viewpoint. The model grew out of interest in the phenomenon that some people experience trauma and it makes their life unmanageable, whereas others are able to overcome the experience (McCann & Pearlman, 1992). The CSDT model coined the term *vicarious trauma* (VT) because individuals construct their realities through perceptions of their lived experience. The model addresses how exposure to intense traumatic content impacts the clinician. The literature and various studies done on vicarious trauma and clinician self-care all stress that no two people respond the same way to trauma, but that the CSDT model provides an opportunity for supervisors to assess if there is a level of impact and then proceed to support the clinicians (Cobb, 1994; McCann & Pearlman, 1992; Saakvitne, 2000). The CSDT model has five components that describe how perceptions are developed: frame of reference, self-capacities, ego resources, psychological needs, and cognitive schemas (Trippany, 2004). Clinicians may have natural reactions to intense emotional stories, but these components serve as an outline that can be helpful in supervision to assess the level of potential VT. The

components of the CSDT model can provide a framework to clinical supervision and how the clinician and supervisor discuss cases. Clinicians who are exposed continuously to traumatic information reconstruct a new meaning of their world as they take in those new experiences.

Trauma can greatly change the way we see the world (McCann & Pearlman, 1992; Saakvitne, 2000). As children we respect and trust our parents. However, children who are abused or neglected by their parents struggle with trusting and respecting any adult because it is no longer safe. Children who suffer abuse, especially at the hand of someone who is supposed to be trustworthy, struggle to maintain healthy relationships because trust has been destroyed. It is important that they develop new, healthy relationships so that they have a safe place to turn. Likewise, professionals in the counseling/crisis intervention field who are exposed to trauma may begin to see relationships as unsafe. It is important that supervision serve as a healthy outlet to help construct new meaning for clinicians and continue to foster their personal and professional well-being.

### **Hermeneutic Phenomenology**

Max Van Manen was interested in human science and identified hermeneutic phenomenology as a research approach to obtain information about particular phenomena. The literature suggests that the human science approach is phenomenological and hermeneutic because pedagogy requires the lived experience (Van Manen, 1990). Van Manen (1990) believed that pedagogy required phenomenological hermeneutics to make interpretive sense of the lifeworld. Using a phenomenological method, the researcher sought to learn the ways of the world according to the human beings who live in it. In order to know the world, one must be in the world. Phenomenology refers to this



connection as *intentionality* (Van Manen, 1990). In order to understand the experience of clinical supervision as a crisis clinician experiences it, this study used hermeneutic phenomenology as the method to extract detail and description as well as meaning from engaging with the clinicians. Using a phenomenological lens, this research focused on what is essential to being and what we hope to continue exploring in the counseling profession. Hermeneutic phenomenology is not just comprehending the phenomena, but understanding it from the inside and then writing descriptions to identify the themes and meanings that emerge (Heidegger, 1972; Van Manen, 1990). Research using hermeneutic phenomenology can be challenging because it is an attempt to construct an interpretive description of some aspect of the lifeworld while remaining aware that the lived experience is also more complex than can ever truly be revealed (Heidegger, 1972; Merleau-Ponty, 1962; Van Manen, 1990).

The methodological process of hermeneutic phenomenology seeks both the descriptive as well as the interpretive. The methodology focuses on the descriptive (phenomenology) and the interpretive (hermeneutic) components of each reflection because they are an inseparable process that is necessary to reconstruct the lived experience (Guimond-Plourde, 2009; Van Manen, 1990). Hermeneutic phenomenology assumes that everything is interrelated and that the whole is more than the sum of its parts (Guimond-Plourde, 2009; Heidegger 1972; Van Manen 1991). The literature suggests that the whole makes the parts what they are and that exploring these parts helps to enhance understanding of the phenomena (Heidegger, 1962; Merleau-Ponty, 1962; Van Manen, 1984). Hermeneutic phenomenology suggests using an interview with minimum structure because reflecting and interaction are central to illuminating thinking

(Guimond-Plourde, 2009). The methodology seeks to understand what meaning participants give to their everyday reality so that the researcher can begin to understand what moves them, rather than what defines them from the outside (Guimond-Plourde, 2009; Van Manen, 1990).

### **Van Manen's Lived Existentials**

Van Manen suggested that the lifeworld is composed of at least four different existentials that are common to all human beings regardless of culture or social situation. The four existentials served as a guide in the reflection process of the research as well as a framework to conceptualize the data that emerged from engagement with participants who shared their lived experiences: lived space (spatiality), lived body (corporeality), lived time (temporality), and lived relation (relationality or communality). Semi-structured interviews provide space for participants to respond on the existential aspects not anticipated by the researcher at the beginning of the process (Guimond-Plourde, 2009). How did your body react when you had to face a crisis? How did the place appear to you when you were in supervision? How did you perceive others around you? How would you describe the passage of time during clinical supervision? These questions helped categorize the data into the four lived existentials and their meaning.

#### **Spatiality**

The first existential is spatiality or lived space. Lived space refers to the awareness of the environment we come to know and live in (Van Manen, 1990). The idea of lived space is more about the feeling individuals have within the space they are in rather than an active awareness. We may feel a sense of loss and fear while standing at Ground Zero in New York City, and we may feel a sense pride or community while standing at the Statue of

Liberty. “We feel a special sorrow for the homeless because we sense that there is deeper tragedy involved than merely not having a roof over one’s head” (Van Manen, 1990, p. 102).

### **Corporeality**

The second existential is corporeality or lived body. The lived body speaks to the way the five senses experience the world around us. Our bodies are inescapable, because we are always physically in the world (Van Manen, 1990).

### **Temporality**

The idea of lived time and how we perceive it depends greatly on the moment. It’s a strange thing, but when you are dreading something and would give anything to slow down time, it has a disobliging habit of speeding up (J. K. Rowling, 2000). The passage of time can be quick or slow depending on the situation; we all experience it, just at different rates (Van Manen, 1990).

### **Relationality**

The lived relation refers to the connections we have with other human beings in our environment. Relationality aligns directly with the idea of social constructivism. In circumstances where people are struggling with an incident, relationality may be closer than usual, because people tend to reach out to make connections when they are facing an impending loss.

### **Summary**

The issues of vicarious trauma and compassion fatigue that could lead to burnout due to lack of self-care are central issues in the counseling field. The issues are heightened in crisis intervention work because the constant exposure, long hours, and large volume of

clients are additional stressors that can impact a clinician. Clinical supervision can serve as a support in these areas and many more. Using hermeneutic phenomenology to explore the lived experience of crisis clinicians, as they perceive clinical supervision, to determine how and if it supports these issues is an area that the literature has not yet explored. The literature indicates a need to understand more of the dynamics within the mental health system, and specifically in crisis intervention, to help make sense of what *is* in hopes to offer recommendations on what *could be*. The role of clinical supervision could play a vital role in helping to raise awareness and provide reminders for self-care by using it during supervision with clinicians.

## **Chapter III**

### **Introduction**

*“To understand the rose, one person may use geometry and another the butterfly.”*

—J. Claudel

A butterfly can bring things into focus that geometry would overlook, whereas geometry identifies angles that the butterfly can miss. No two methods are alike, and multiple methods are valuable and necessary in order to better fully understand the whole of an object. Many tools are used to study phenomena, and the tool selected will affect the perspective from which one examines the phenomenon. A quantitative method provides a measurement and can explain the effectiveness of a particular strategy or an intervention. This study took a different angle: rather than examining effectiveness as one aspect, it examined the experience and the meaning of the intervention as a whole. Using Van Manen’s hermeneutic phenomenological approach, this study engaged both the researcher and the participants to reveal the lived experience of clinical supervision in order to determine how and if it supports professional well-being as well as personal competence. This chapter addresses the research design, sampling methods, and data collection and analysis, as well as the procedural methods, used to enhance the credibility and accuracy of the interpretations derived from the data collected in this study. This chapter explores the components of the design to gather the essence of the experience of supervision for clinicians in crisis work as well as outline the reasons for using Colaizzi’s method of inquiry to extract the rich detail that informed this study.

### **Research Design**

Research has been done on crisis intervention, clinicians, and clinical supervision

individually, but an insufficient amount of literature has been produced on how they impact one another. Using a qualitative design, this study provided a unique opportunity to listen to people talk about their experiences, rather than what defines them from the outside world (Guimond-Plourde, 2009), regarding clinical supervision and how or if it supports them in their work as crisis clinicians. This approach was particularly germane in this study because little is known about the experiences crisis clinicians have in clinical supervision. The qualitative lens in this study provided the chance to capture more than just a description of the lived experience, but also an opportunity to generate interpretations of the real lived experience. In qualitative research the researcher is inviting participants to share their life experiences, which requires a relationship between both parties. As the researcher, I sought to understand the essence of how the crisis clinicians attended to their world because the participants in this study would share their perception as a form of their interpretation (Boyd, 1993; Van Manen, 1990). The reason to use qualitative designs for research is because the phenomenon of interest requires it—it is inherently qualitative and there is a high degree of ambiguity (Patterson & Williams, 2004). In this study, the rich descriptions and interpretations derived from the data were used to identify themes and issues that could be further examined with quantitative methods and the results more appropriately generalized to relevant populations.

The researcher chooses participants who then become experts on their life experience that they choose to share within the study. The use of qualitative research is in line with the counseling field, because the skills and training common to counselors are applicable to the process of inquiry (Merchant, 1997). Qualitative research relies greatly on the researcher, because all information flows through the researcher. Given that the

researcher is central in qualitative research, it is important that all biases and preconceived notions are put aside when entering the participant's lifeworld. Bracketing is an intentional process whereby the researcher removes his or her own biases and explains the phenomenon in terms of its own intrinsic system of meaning (Merriam & Associates, 2002; Newsome et al., 2008). The researcher needs to be open to self-disclosure and explain the process of how he or she is putting aside all preconceived notions in order to remain open and receptive to the lived experience of the participants. In a qualitative design the researcher is also looking for commonalities among the experiences (Newsome et al., 2008).

### **Sample**

Although in many other research designs sampling can be randomized, participants for this qualitative study were selected specifically because they represented people who had lived experience with the phenomenon of interest. Sampling is key to a solid qualitative inquiry, and it also enhances the understanding of the dilemmas of qualitative validity (Morse & Richards, 2002). The sample chosen for this study met the criteria necessary to supply rich, meaningful experiences with the phenomenon. In addition to selecting crisis clinicians who had experience with clinical supervision, participants were selected with an eye toward providing some diversity of age, gender, and race. Heidegger (1962) believed that every encounter involved interpretation that is influenced by the individual's culture and background. Thus, this sample had to not only represent the population working in crisis, but also include people with different backgrounds and culture.

The sample was drawn from crisis clinicians who function as 24/7 first responders

to both small and large-scale crises in a crisis intervention role within a crisis response agency in Western Pennsylvania. The sample was assembled from crisis clinicians who responded to an invitation to participate survey (Appendix C). Once the participants contacted the researcher and expressed interest in the next step of participation, the researcher narrowed down the group and selected the sample based on the following criteria: clinicians who had worked in the crisis field anywhere from 2–5 years, who had been trained in Critical Incident Stress Management (CISM) and crisis intervention, and who had received clinical supervision. The optimum size of the sample was six candidates in order to reach data saturation for this qualitative study. Clinicians with less than 5 years of experience may not have had an adequate quantity or variety of exposures to the supervision experience. For the purpose of the study, the researcher chose the first six participants who made contact with the researcher and met the necessary criteria. The participants were asked to engage in one-on-one semi-structured interviews and an additional focus group with the other participants.

An initial invitation to participate in the study was extended to clinicians in two different counties in Western Pennsylvania who do crisis intervention work in a 24/7 first response organization. The invitation forms were sent via U.S. mail to the agencies. The invitation provided a description and purpose of the study. The researcher provided contact information for volunteers who were interested in participating in the study.

### **Data Collection**

Subscribing to a hermeneutic phenomenological method using Colaizzi's method of inquiry (Appendix A), the researcher began data collection by conducting audiotaped semi-structured, one-on-one interviews with the participants. One-on-one interviews and



dyads are the most common methods of collecting data in qualitative research (Polkinghorne, 2005). Once the semi-structured interviews were complete, the researcher transcribed the data. The transcribed data were explored, and specific statements were identified using Van Manen's existentials. Once the statements were labeled with Van Manen's existentials of lived time (temporality), lived space (spatiality), lived relation (relationality), and lived body (corporeality), meanings were formulated. Analyzing the statements and labeling them with Van Manen's existentials is a vital step in hermeneutic research as it emphasizes the importance of words used by the participants in describing and interpreting the lived experience with a phenomenon. After the meanings were formulated, they were grouped into cluster themes to begin the process of categorizing the meanings into clusters, making the large amount of data more manageable and relatable. After the meanings were grouped into cluster themes, emergent themes were identified. The themes were then written down in a list format and provided to the audiotaped focus group for discussion to determine accuracy, as well as to encourage the participants to elaborate on the researcher's findings. Once the focus group was complete, the researcher transcribed the interactions and examined the group dynamics as well as the themes addressed by the participants based on observations. The researcher completed the same steps in analyzing the data as in the one-on-one interviews. The researcher explored the transcriptions and identified significant statements relating to the phenomenon of interest. Once the statements were identified, meanings were formulated. After meanings were formulated, cluster themes were identified and emergent themes were developed. Only the researcher had access to the data, as it was locked in the researcher's office when not being used for transcription.

The one-on-one interviews lasted for 45 minutes to 1 hour and were audiotaped. The interviews were conducted in a classroom at Duquesne University, and all tapes were kept locked in the researcher's office unless being used for transcription. At the interview the participants were asked if they would engage in a focus group with other crisis clinicians to discuss the findings of the interviews. The 1-hour focus group was conducted at Duquesne University with the participants and audiotaped. The researcher provided a written record of the themes and patterns identified from the individual semi-structured interviews to the participants so that they could openly discuss these topics with one another. The audiotapes of the interviews were subsequently transcribed for analysis. The resulting transcripts were numerically coded so participants' names were not recorded. Only the researcher had the key to link the coded transcripts to each informant. The key was kept in a locked file, along with all written material related to this study, which was kept in the researcher's office. Following publication of the study, the tapes and transcripts were destroyed to further protect the participants' confidentiality.

The researcher was the instrument in this hermeneutic phenomenological study. After the data were collected, the researcher transcribed and analyzed the data discussed in the following chapters. The researcher extracted the themes, descriptions, and meaning that emerged from the engagement with the participants. The analysis sought to uncover the meanings and interpretations of the participants and how they have experienced clinical supervision in crisis intervention work to determine how and if it was a support for professional competence and personal well-being.

### **Hermeneutic Phenomenological Approach**

Like other forms of phenomenology, hermeneutic phenomenology is concerned with the

experience as it is lived and focuses on aspects within the experience that may seem trivial or that are typically taken for granted (Wilson & Hutchinson, 1991). The researcher once worked with a client who was recounting the story of her neighbor jumping off the roof to his death and listened closely as she divulged the details of the situation only to discover that her details were drastically different from the details of another witness who happened to be a family member. We all remember details differently based on our relation to the event and based on our past experiences that led us to that moment. The meaning we create is unique and reflects our individuality. Hermeneutics is the process of exploring how people understand the world in which they live (Gadamer, 1989; Van Manen, 1991). We all can look at structures and provide dimensions—we do it in geometry—but in hermeneutic phenomenology we want to know how the phenomena is interpreted. Heidegger (1962) identified three components of hermeneutics: an attempt to understand the phenomena of the world, an attempt to understand how we understand the world presented to us, and an attempt to understand being itself. The second component identified by Heidegger was the most significant in terms of this research study: How do people interpret the world around them? In hermeneutic research, interpretation and meaning are the primary focus (Gadamer, 1989; Van Manen, 1991). What sets hermeneutic phenomenology apart is the tradition of looking at the phenomenon and gathering the descriptive as well as the interpretive qualities of an individual lived experience. There is a lot of overlap in phenomenological methods, but hermeneutics is not a process where data are gathered based on field observations; rather, hermeneutic researchers seek to engage in an interactive process (Dilthey, 1976).

Hermeneutic phenomenological research is an interaction with participants among four different activities: turning to a phenomenon of interest, investigating experience, reflecting on themes that characterize the phenomenon, and describing the phenomenon through writing (Van Manen, 1984). The four-step process of phenomenology guided the researcher through the participants' lived experience, provided a structure to make sense of themes that emerged regarding the phenomenon of interest, and provided the foundation for researcher interpretations.

### **Turning to a Phenomenon**

Every inquiry begins with some interest or curiosity in understanding how things work or how they could work better. There is a commitment of thought about a particular phenomenon, a desire to examine the parts that make it what it is (Van Manen, 1984, 1997, 2002). The researchers immerse themselves within the context of the phenomenon of interest to make sense out of the people who experience it. This is the first step in the phenomenological process, and it is one of seeking description and meaning. Van Manen (1984) explains that the phenomenological description is always about interpretation and that no specific interpretation could exhaust the possibility of another rich description. Learning the lived experience to better grasp the phenomenon is a constant process, and each experience holds value that contributes to the overall interpretation and understanding of the phenomenon of interest. The phenomenological study motivates questions and requires the researcher to fully face the phenomenon, as well explicate any assumptions or pre-understandings (Van Manen, 1997). The phenomenon of clinical supervision in crisis intervention work and how it supports personal and professional well-being was the overarching inquiry of this study.

## **Investigating Experience**

Once the phenomenon has evoked thought and curiosity, the researcher conducts an existential investigation of the lived experience. This phase of phenomenological research is the exploration to generate data. Van Manen (1984, 1997) instructs researchers to identify a population of people and use their human experience to begin the process of collecting data. The existential investigation includes phenomenological questions to draw out participants' descriptions. For the purpose of this study, using clinicians who work in crisis intervention every day and investigating their experience of clinical supervision provided a rich and honest description of how they perceive the process. Researchers need to stand in the midst of the world they are attempting to study and actively explore the lived experience and all of its aspects (Van Manen, 1984, 1997, 2002). A few standing questions were used in the semi-structured interviews with the participants in order to extract rich detail and narratives of the lived experience. These were not questions that were directly asked of participants, but rather questions that motivated the overarching inquiry of how clinicians makes sense of their experience of clinical supervision in crisis intervention work. The questions included: How does a clinician receive supervision in crisis work? Are the clinicians receiving the support needed to do crisis work? How are the clinicians receiving help monitoring consumer welfare?

## **Reflecting on Themes That Characterize the Phenomenon**

When using a selective approach to phenomenological research, it is the researcher's responsibility to highlight or pull out themes or phrases that are essential to the experience of the phenomenon (Heidegger, 1972; Van Manen, 1991). In this phase of

phenomenology, it is important to reflect upon themes, because this research, unlike any other research, makes a distinction between appearance and essence (Van Manen, 1984). The reflection phase indicates a need to explore the data and determine what themes emerge that help create more understanding of the concept being studied. This phase encourages the researcher to inquire into what it is that makes the lived experience what it is. In this study, the reflection phase occurred in the follow-up with the participants. After the initial collection of individual narratives from the participants, a focus group was gathered to clarify and discuss the themes that emerged from the semi-structured interviews. Additionally, this phase of phenomenology requires thematic description from the literature to enhance understanding of the lived experience in the data (Van Manen, 1984, 1997).

A triangulated design was necessary in order to gather a rich and meaningful exploration of the lived experience of crisis clinicians, as they perceive clinical supervision in crisis work. Triangulation is the process of gaining multiple perspectives from completed studies on the same topic that address each other's findings (Morse & Richards, 2002). Triangulating the data is important to enhance the validity of the findings. In this study, one-on-one semi-structured interviews were performed to explore the lived experience of crisis clinicians in regards to clinical supervision. Using more than one method of data collection enhances accuracy and makes the data more trustworthy (Creswell, 1998; Eisner, 1991). After initial analysis by the researcher, themes were uncovered and focus groups were held to discuss the themes among the group members. Two levels of engaging with participants expanded the data and also served as a check to determine if the themes pulled by the researcher were valid.

Triangulation uses the same research question from different angles to ensure that as much information that can be gathered is collected. The credibility of the data can be tested within the triangulation design because the researcher takes the initial data and checks the themes with the group that has already participated.

### **Describing the Phenomenon Through Writing**

Merleau-Ponty (1945) said, “When I speak I discover what it is I wished to say.”

Phenomenology is the application of speaking or language to the lived experience. This phase requires attention to the use of language when describing the lived experience. The writing process can be split into two subphases: thematic and existential. In the subphase of writing thematically, the phenomenon of clinical supervision in crisis work illustrated some themes of how clinicians feel supported and how confident they feel that their consumers are being managed. In the subphase of existential writing, the descriptions were categorized into the four existentials (lived time, lived space, lived body, and lived relation) identified by Van Manen (1997) in order to combine experiences into the whole or Gestalt of the lived experience of the phenomenon. The methodology encouraged the participants of the study to describe their own experience of the phenomenon.

Phenomenology identified four existentials that provided categories in order to help clarify meaning making of the lived experience: lived body (corporeality), lived space (spatiality), lived time (temporality), and lived relation (relationality) with others (Van Manen, 1990). Phenomenology motivated this research to understand the meaning and experience of the phenomenon, not the cause. The four existentials helped to categorize the description of the lifeworld or phenomenon of interest. The existentials are grounded in all lifeworlds, regardless of culture or social situations (Van Manen, 1990). The

existentials provided a guide to categorize the data in the research process.

### **Colaizzi's Method of Inquiry**

Colaizzi (1978) suggested a method of inquiry that is consistent with this hermeneutic phenomenological approach. His seven-step method provides a logical guideline for conducting a phenomenological inquiry and validating the information uncovered from the semi-structured interviews. Colaizzi's (1978) method is rooted in phenomenology and holds a hermeneutic component that focuses on formulated meanings. Formulated meanings are an essential tool in qualitative data analysis (Colaizzi, 1978). Frequently in qualitative studies there is a concern about a saturation point; that is, knowing when the researcher has gathered enough information for it to be valid. In using Colaizzi's method, the saturation point is agreed upon by the researcher and the participants. In this study, a prompt during the semi-structured interviews as well as the focus group was provided, asking, "Is there anything related to the topic of supervision that I did not ask that you feel would be important to share?" The following steps represent Colaizzi process for phenomenological data analysis (cited in Sanders, 2003; Speziale & Carpenter, 2007). A visual description of this process (Appendix A) highlights the process of analyzing transcripts and immersing in the data.

1. Transcripts are read and reread, exploring for common themes and categories.
2. In each transcript, specific statements that speak to the overall phenomenon of interest are extracted.
3. The specific statements generate meanings that need to be formulated.
4. The formulated meanings should be sorted into categories and themes.
5. The findings are integrated under the phenomenon of interest.



6. The structure of the phenomenon is described.
7. The researcher takes the findings back to the participants in order to validate the themes and meanings.

Using Colaizzi's method aligned with the ideals of hermeneutic methodology required the researcher to immerse herself in the data in order to formulate potential meanings and patterns from the participants' lived experience. The seven steps recommended by Colaizzi informed the process used in this study of interviews and transcripts being explored for themes, which were then brought back to the focus group for validation.

### **Bracketing Methods**

The qualitative nature of the study implicates the researcher as the only instrument interacting with participants and analyzing data. Participant observations, interviews, and field notes are the main methods of data collection. Researchers use verbatim transcripts to illustrate that the data are accurate and complete. There has been controversy over the validity and reliability of these qualitative research methods given that participant interaction with the researcher becomes the vital component of the data collection and findings (Erikson, 1986). However, qualitative researchers need not be immobilized by their instinctual biases. Bracketing is a method to mitigate preconceptions of the researcher in qualitative studies, and there are various forms of bracketing that can be used to keep the researcher aware of the data sources. Qualitative research uses interactions with participants to gather rich description and meaning, which is helpful but can also induce a subjective bias (Tufford & Newman 2012). Researchers are subject to letting assumptions and values influence their interpretations of the data. They also may

have a close connection, an emotional investment in the phenomenon of interest in the study. Bracketing can assist in protecting researchers from examining emotionally challenging data and being unaware of how their biases might influence the findings (Tufford & Newman, 2012).

Bracketing can occur at different points in the research process. In qualitative research, some investigators may bracket throughout the study, whereas others bracket only during analysis (Ahern, 1999; Giorgi, 1998; Rolls & Relf, 2006). Bracketing can be a reiterative process; the researcher can use the method as a checks-and-balance system to ensure that all data interpretation is fresh and not based on the researcher's prior experience. It can help to ensure that the researcher's data are viewed and considered separately from the data derived from the study's informants.

Several bracketing methods are available to support researchers using a qualitative design. Reflexive journals, memos, and outside source interviews are just a few of the methods that researchers can use to remain self-aware of their preconceived notions of the phenomena (Ahern, 1999; Cutcliffe, 2003; Rolls & Relf, 2006). Two methods of bracketing were used in this study to aid the researcher in both the research question development process as well as the data analysis process. I come from a crisis intervention background, and the experience of clinical supervision as an intervention to support professional competence and personal well-being is one that has been of great interest to me. I used reflexive journaling as I decided upon a few questions that would drive my study as well as my semi-structured interviews with participants. I used the journal as a way to write down my own thoughts and ideas about the concepts in a place where I could acknowledge that I am a part of this study because of my passion for this

work. In a way, writing in the reflexive journals gave me an opportunity to put my thoughts and feelings out there without the need to stifle them and pretend that they did not exist. The reflexive journal helped me put to words why this study was so important and in some ways to share my own experience with the phenomena. Additionally, I used the reflexive journal throughout the process to write about my own personal values and had an opportunity to write in first person what I wanted to say, without literature or participants to support it. It was a liberating experience for me and helped to keep me focused in the research process and remain fully present to the data and the participants' lived experience. Another method I used was writing memos during the data collection and analysis. Similar to the reflexive journal, but a much more informal process, I used memos to write down my thoughts and experiences of the interviews and the participants' comments. This process enabled me to write down judgments or values that may have clouded my interpretation of the data. These methods supported me to make sure that the participants, who so willingly gave up their time to share their lived experience, were heard in this study.

### **Limitations of the Study**

As with any study, there are limitations that accompany a process that involves human interactions and interpretations. There are general limitations to qualitative data, and this study was no exception. Some of the limitations that exist in qualitative studies include research quality that is heavily dependent on the researcher's skills and can be influenced by the researcher's biases; no known saturation point for the data; confidentiality and anonymity can make it difficult to validate the data; the researcher's presence during data collection can influence the participants' responses; and rigor can be difficult to maintain

and assess. In this study, one of the limitations that I was very aware of as a researcher was my presence and the impact it would have on the participants. One way to account for this possibility was to provide the participants a survey to express their experience of sharing thoughts and beliefs with the researcher after the interviews were complete. Although I could not eliminate the possibility that my presence may have influenced their responses, gathering this information anonymously after the interviews provided insight into their perception of the experience (Appendix D).

Another limitation was using human subjects as a means to collect the lived experience. Although every measure was taken to uphold confidentiality, sharing a personal detail with a stranger has implied risks and can leave participants feeling vulnerable or perhaps unwilling to reveal the entire experience.

An additional limitation to the study was my bias as the researcher. As described earlier, I have a deep interest in the subject matter as a professional and as a researcher. Crisis work is a passion of mine, and I had to constantly be aware of my own bias and thoughts throughout the process. The bracketing methods assisted in keeping me aware and present for the participants in the study.

### **Summary**

This chapter described the design of the study along with the methodology used to conduct interviews and focus groups in order to extract rich description and meaning for crisis clinicians, as they experience clinical supervision. The researcher was faithful to the bracketing methods in order to best serve the participants in this study who offered to share their lived experience so that we may better understand the phenomena of clinical supervision as it is perceived by crisis clinicians on a daily basis. The research design,

sampling, data collection, and methodology discussed in this chapter were carefully selected and conducted to accurately and appropriately reflect the true lived experience of the individuals who gave up their time to share their story.

## Chapter IV

### Research Findings

*“There is no greater agony than bearing an untold story inside of you.”*

—Maya Angelou

This chapter presents the findings that resulted from the participant interviews and the focus group conducted for this study. The participant demographics and their responses in the interviews and focus group, regarding the lived experience of clinical supervision for clinicians working in crisis intervention, are included here. Additionally, this chapter discusses the researcher’s observations on each informant’s interview experience and the focus group dynamics. This chapter concludes with the identification of emerging themes in accordance with the four lived existentials described by Van Manen (1991): temporality, spatiality, corporeality, and relationality.

#### Participant Demographics

Six individuals met the necessary criteria and were generous enough to volunteer their time and share their story for the purpose of this study. The six informants varied in age, race, and gender, as described in the Table 1 (also see Appendix F).

**Table 1**

#### Informant Demographics

	Age	Gender	Race	Years of Experience
Informant #1	33	Female	Asian	2.5
			American	
Informant #2	31	Male	African	3

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			American	
Informant #3	47	Male	Caucasian	5
Informant #4	29	Female	Caucasian	3.5
Informant #5	44	Male	Caucasian	4.5
Informant #6	34	Female	African	4
			American	

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All participants invited to participate in this study had been working in crisis intervention for at least 2 years and for no more than 5 years. Additionally, all of the participants had been enrolled and completed crisis intervention training, including Critical Incident Stress Management (CISM) and Critical Incident Stress Debriefing (CISD). The CISM and CISD trainings are a standard in Western Pennsylvania and are intended to provide crisis workers and other first responders with insight and awareness regarding people who experience trauma or disaster. The trainings are a foundation for understanding that all people have the potential to suffer negative consequences from a critical event, and that people may respond in different ways. All of the participants reported receiving some form of clinical supervision, although the frequency of supervision varied widely from once a month to brief moments in between crisis calls.

### **The Interview Process**

A standardized protocol was used to structure the individual interviews (Appendix G), but additional questions, shown below, were asked in order to prompt the informants to elaborate on certain items and issues that were introduced in the discussion. Prior to each interview, the researcher read the purpose of the study and reviewed confidentiality with the interviewee. The same purpose of study (Appendix H) was read to each informant to

ensure standardization of the process and a common understanding of the study's intent and the data collection process. The following guiding questions were used in the study to structure the systematic examination of the lived experiences of the participating crisis clinicians:

1. How do crisis clinicians experience supervision in crisis work?
2. How do clinicians describe their relationship with their supervisor?
3. What does supervision mean to clinicians in crisis work?
4. What is the focus of supervision in crisis work?
5. In what context is supervision received?
6. How do crisis clinicians describe the purpose of supervision?

### **Informant #1 Interview**

Informant #1 arrived early and seemed eager to share. I reviewed confidentiality and how the information she shared would be protected. I also reviewed the purpose of the study. After reviewing the purpose of the study and explaining that I wanted to hear about her experiences of clinical supervision, she instantly seemed to express frustration at the mention of supervision. The participant physically reacted to the word and readjusted herself in her chair shaking her head. Nonverbally, the participant appeared to have a lot of energy and struggled to sit still. It appeared that she was eager to begin and ready to share her story. Informant #1 was vocal about her struggles in her position and the lack of support she felt that she received. I started the interview inquiring about her role at the crisis agency. She described five different responsibilities that she had as a crisis clinician: "I do a lot of things at my job. I'm a crisis clinician and I do crisis intakes, crisis assessments, crisis support, mobile crisis, and phone crisis. On any given day I do



one or all of those different things. It's exhausting but exciting!" I reflected back to informant #1 that it appeared she wore many hats and asked how she juggled all those various roles. She spoke about her need to constantly manage things because she felt like "I have no choice but to manage it because it can't spill out on my calls. The consumer is always my priority; sometimes I just wish I was someone's priority at my job."

The participant discussed the business of her job and the urgency that her job demanded in everything she did while she was on shift. The participant shared,

I'm like an air traffic controller. I have to manage everyone's planes and put out every potential fire. Sometimes we have close calls that are turbulent and leave you sweating and other times the ride is smooth. It's just you and your partner and this event trying to get these planes to safety, whatever safety is for that person. It's a lot of pressure and a huge amount of responsibility.

I shared with the participant that she seemed to take her job seriously and placed a lot of value on her role in crisis. I also shared with her that air traffic controllers experience a lot of stress and asked her to talk more about her management of stress in the work she does. The informant took a deep breath, looked at me, and simply said, "You have no idea how much stress I carry with me every single day." The informant continued,

When you see something that you are never prepared to see, death or total poverty and everything in between, and you're expected to be the "expert," it is terrifying. I am constantly aware that I am the one who has to make a decision here. I make a choice to tell the plane which direction it can go in, and what if it is the wrong one? I mean, I guess I am not that important or

powerful but still it leaves my heart beating just a little faster when I think about that.

The informant and I talked about how powerful that analogy was because an airplane impacts a lot more than one person. In sticking with the analogy that she had used, I asked about the air traffic controller's need to remain completely focused due to the level of dangerousness and intensity. She smiled and said, "I think or at least I hope that when I'm on a call, I'm there." We discussed how difficult it can be to maintain that intense concentration, and how that could shift focus from the consumer. She explained how hard it is to come into work fresh so that she can remain fully present.

I mentioned to her that I wanted to come back to her earlier statement, "I wish I was someone's priority." I suggested that it seemed to imply that no one was looking out for her the way she was looking out for the consumer. The informant expressed that she felt isolated at times and has only been able to rely on her partners for any feedback and support. She continued by describing the special bonds between her and her peers and described them as "unique." I inquired specifically about her experience of clinical supervision. The informant sat up in her seat; presented as very alert, as opposed to her casual and relaxed nature prior to the question; and responded with a slight chuckle. I gave her space, and she took that opportunity to ask me again if this was completely confidential. I assured her again that her name would not appear in any part of this study and that only I would listen to this tape, review the transcription, and integrate the information provided with all of the other informants in an anonymous fashion. She then went on to explain,

Honestly, I get administrative supervision for "lates" or paperwork, but am

not sure I have had like real clinical supervision in months. I can't tell you the last time I sat with my supervisor and really talked with him about me or about cases. It's so frustrating to be asked to do this work, which is so intense, and have no one know what you're doing. I mean isn't there a liability in that? I just don't know.

I invited the participant to take this opportunity to share what her expectations of supervision were in a crisis setting. Informant #1 went on to share that one of the most difficult moments of her time, as a crisis clinician, was when she walked into a situation where a man had just lost his wife and child in a murder-suicide. The participant continued explaining that the man was inconsolable and the bodies of the deceased were still on the scene. I watched as the participant shared her painful story. She took breaths in between sentences as if as she was remembering it and she was seeing it again in her mind. Informant #1 shared,

I am standing there trying to comfort this man who just lost his whole world and he is just broken. You know? There is nothing I can say or do that will change the outcome so I am just supporting him. I'm trying to make sure calls are getting made to his other family so that he won't be alone. I have to ignore the deceased individuals and stay with this guy and I am some stranger to him.

The participant seemed to be visualizing the event as she verbalized it to me. She explained that it was so hard to be there and witness that event. She then said, "Do you know what I did after that call? I went on the next one." The participant shared that it was her duty to go to the next call. She had a smile on her face almost as if she realized how

awful it sounded as she said it out loud.

Informant #1 continued by explaining that the next call was a husband who had become physically violent with his wife:

I mean is that polar opposite or what? Here I am walking off an emotionally draining moment to a call where a husband is a complete jerk.

I wanted to get authoritative and be like, do you not know what you have?! Some guy just lost his wife and you're sitting here abusing yours.

Of course I didn't because my role was to respond to the wife while the police handled him. It's just kind of crazy.

As the participant shared this story of back-to-back crisis calls it was apparent that this was a powerful experience for her because the initial question was about supervision and she related it to a specific example that she felt demonstrated her need for supervision.

The participant shared, "I just know that we are a group of unique individuals who experience some really screwed up downright sad stuff. We count on each other for feedback and to keep one another in check because no one else does." Informant #1 explained that her expectation that day would be for the supervisor to at the very least check in with her about her work and her emotions, but that never happened. The participant stated, "I walked home with that on that day. I carried it with me everywhere I went. Maybe I still do in some ways."

The interview continued on with discussion of some of the ways supervision could be helpful and what she felt the purpose of supervision was for her. The participant explained that the most significant value of supervision that she wished she had would be to talk about the stress of calls. Informant #1 continued, stating, "I think that supervision

would be helpful if I could really discuss cases and my emotions around it. I can let go of things once I have that moment and get some perspective.” She discussed not knowing most of the time whether she did a good job or not, but at the end of the day knows she tackled everything with the purest of intentions. We talked about whether she felt as if her skills have improved since taking this job, and she very bluntly stated,

I think they have declined because no one has really paid attention to my work. I think that if I had supervision or just someone here to mentor me I would be able to discuss cases and really talk about my emotions so I could compartmentalize. Instead, it’s one call after the other. I know it sounds dramatic, and my partners would probably rag on me about it, but it’s true. It’s Groundhog’s Day.

### **Informant #2 Interview**

I met with informant #2, and he appeared hesitant to begin the interview process. He entered the room quietly and appeared uneasy in his seat. I started by reading him the purpose of the study and reviewing confidentiality with him. He asked whether other people had come in and vented frustrations over lack of support in the field, and I explained to him that confidentiality was important for each participant. After hearing the confirmation of confidentiality, he appeared more at ease as we continued the interview. I also reminded him that, if he was willing, he could engage in a focus group at a later date to discuss some of the themes that emerged from the interviews. He immediately said, “I will definitely be a part of that group.” His interest in meeting with fellow crisis clinicians to discuss the work and supervision caught my attention. I inquired about his willingness and he explained, “It’s just nice to know there are people like you who get

what it is that we do. Makes you feel like you have a crew, you know what I mean?” It seemed as if he was talking about the sense of team and belonging and that unique bond between partners that was mentioned in other interviews. I simply nodded my head and added that he would have that opportunity if he wanted.

After this initial conversation, informant #2 appeared to be more at ease and relaxed and sat back in his chair. I began the interview, asking him to talk about his role as a crisis clinician. He explained,

It’s the best job I have ever had. I meet the most interesting people every single day. I get to work with people from all walks of life. I go out on mobile crisis and we do what we can to stabilize people so they don’t end up in the hospital. But it’s more than that. I get to see people after a huge disaster or event and give them a little hope, you know? It’s a really cool job.

Informant #2 displayed a lot of enthusiasm while discussing his job and seemed to be very proud of the work he does. He used the word “get” instead of “have,” implying that it’s an opportunity, not a burden, to do the work he does; it was refreshing. I shared with him that he seemed to really enjoy his job. The participant smiled and said, “I love going to work every day. I never know what I will get to do. There is a ton of variety, which is right up my alley.” I reflected back to him that variety could be a nice change of pace and at the same time could create some frustration and even stress for people.

Informant #2 responded,

Hey listen it’s not for everyone. Change and variety is a constant at my job.

You have to be flexible, you know? If you can’t be then you won’t survive.

There is no black and white, right or wrong, it's just a lot of grey. I like that.

I suggested to him that for some people that could be a challenge but the variety and change seemed exciting for him. He agreed and continued discussing his love for the work.

He described some situations that he characterized as impactful for him. Informant #2 expressed excitement in sharing his pride for the work he does. He shared, "We have other calls that were just so amazing. You know; where we made a difference. Helped someone or did something that could not have been if we had not been there." After hearing some of his stories that he considered to be great successes, I asked him about some of the tough moments he has experienced in the work. Without hesitation, he replied, "Oh I have those stories. I have a bunch of those stories unfortunately." He continued by sharing a story about a crisis he responded to about a man who lived in a cardboard box back in an alley. He talked about this man, who was a veteran and now was homeless and had been loitering outside a local restaurant. Informant #2 shared that the man was very untrusting and had no family or friends. The participant explained, "I felt for him. I really did, I mean he was a vet and homeless; just didn't seem right." Informant #2 talked about feeling totally paralyzed in helping him because the man was untrusting and had been let down by so many people. The participant explained, I mean you see someone who you can help and all they have to do is let you, but they can't. It's so frustrating! I tried to meet with my supervisor and some other people in the building to talk about ways to connect with this guy; no one was even around to help. I started feeling like the guy,

like I was on my own and had to figure this out. I knew winter was coming and was working against time.

Informant #2 paused for a moment and then stated,

He died. I went to see him and he was dead. I mean I didn't know him. I only knew his first name and that may not even have been real. But no one deserves to die like that, not someone who gave up so much for others. That was bad. I felt bad for him and worse I felt like a total failure. I didn't like my job that day.

I took a moment to let that sink in and was really struck with this enthusiastic man who exuded passion when he talked about his work that now looked defeated after sharing a difficult moment. He went on to share that there were other moments and cases that hit him, but that was the first one, and it stays with him.

He talked about touching base with his supervisor after the situation and she patted him on the back and said, "I get it." Informant #2 then said, "How could she get it? She wasn't there. Don't we preach that we don't really 'get' anything because we never walked in that person's shoes?" I shared with him that it had to be difficult to sit there and hear that after such an emotionally draining moment. I inquired further about his overall supervision experience. The participant said,

It's funny because I always think of that moment and how easy it could have been for her to give me supervision or counseling and how quickly she dismissed me. If she had done that and never helped me again I probably would be sharing a different story with you. I took that so personal. My experience of supervision is that I get it in some form, I



touch base with someone, but I am never satisfied.

I asked the participant to elaborate on never being satisfied with supervision, and he explained that although he received it and every once in a while he talked cases, he never gets attention for himself and his clinical work. The participant shared,

I never know where I stand, in terms of my skill level. You know when things go bad on a call that is when I get supervision the most. Not bad like death, because that happens on a lot of the calls, but bad in terms of I missed something, then a supervisor really wants to be a supervisor, you know, protect themselves, which is pretty telling if you ask me.

I listened to informant #2 talk about his experience of supervision and his frustration with the lack of support. He was animated when talking about the work and in discussing the supervision that he felt he had missed out on as a developing professional.

The participant, who had been working as a crisis clinician for almost 3 years, described feeling uncomfortable in his own skin on calls at times because “I feel like a fraud.” I asked him what that meant, and he explained that he wondered if he knew what he was doing at times. He continued, “I used to feel really confident, like I was good at what I was doing, but the last maybe 6 months, I feel like maybe I’m fooling myself and the consumer.” I took the opportunity to ask about his expectations for supervision and how it could support some of those strong feelings he was currently dealing with as a professional. The participant said, “I want to sit and meet with my supervisor. One hour, uninterrupted by crisis, to sit and be heard. I’m game for whatever they want to talk about, but if I could just get some time to really talk I would be happy.” I listened to him speak and couldn’t help but think that he was talking about needing his own crisis team in

supervision. He was searching for the supervisor to support him, give him feedback, and help get him to a level where he could feel comfortable and maybe even confident again in his work. Informant #2 also shared, “I want supervision to at least acknowledge that this job can take its toll on people. I don’t want to feel like a crybaby, that a call touched me in some way. I want to feel like I’m not alone and that this work is hard.” I acknowledged his desire and asked if he felt isolated and he responded with a smile and said, “I know my team has my back.” I asked the participant how he would rate his skills on a scale from 1 to 10 and he replied,

I would like to think I am an 8, but I think if I am being honest I would say

I was at an 8 and maybe I am now like a 6. That is hard to say out loud.

With all the stuff we have to see, knowing that maybe my skills are not

being developed as they should is really hard to swallow.

I inquired why he said a 6 and not a 4, and he shared that he felt he had a good foundation that served him well and that his team helps him stay on track. I then asked what would push him to that 8 or 9 level, and he explained that supervision would be a huge push for him and group supervision would be ideal. The participant responded, “I mean I think support, someone to bounce this stuff off of.” Informant #2 thanked me for an opportunity to talk about his work and walked out of the room and said he would look forward to the focus group. I remember thinking as he walked out that if nothing else this time and space to share might have served him well.

### **Informant #3 Interview**

Upon arrival, informant #3 appeared casual and relaxed as he took his seat a few desks away from me in the classroom. Every other participant sat directly across from me, but

this participant sat further into the classroom, as if I was going to be teaching him. I commented on his distance and asked if he was comfortable as it would just be the two of us talking today. He nodded his head affirmatively and moved up a few seats in the room. I reviewed the purpose of the study and explained confidentiality with the participant; he smiled the entire time and said he was familiar with the process. We began his interview with me inquiring about his experience as a crisis clinician. He explained that had been doing this work for just about 5 years. The participant talked about why he first got interested in the field and what has kept him there for the last 5 years. He spoke fondly of his work and his contribution to the field. He said, "I've made some imprint, several times along my way and I am proud of that." Informant #3 spoke about his role in some of the major disasters in the area. The participant said, "I have the privilege of getting called into to some of the larger events in the area. The stuff that people might see on their local news, I am behind the scenes supporting the victims, helping the community."

Informant #3 explained that life as a crisis clinician is challenging and fulfilling in so many ways. I inquired about a specific experience that has stuck with him over the past 5 years, and he chuckled stating, "Where to begin?" The participant began to share a story about a disaster that occurred a few years ago that had particularly touched him. He talked about being a part of the response team and handing someone a cup of water after they had just lost their home and a child in a four-alarm fire. He describes the situation as, "one of the most powerful moments I've ever experienced." The participant continued,

I remember that night so clearly. I know it sounds ominous, but truly I if I close my eyes I can picture everyone's face and the whole scene. I remember the smells and the tears of all those people as they helplessly

watched everyone and everything that they love burn in front of them. Informant #3 was visibly emotional retelling this story but continued on, explaining that he can't remember the words he said or if they held meaning, but he remembers being present. The participant shared, "I handed this woman water. She lost her whole family. I gave her water. It's all I had." I reflected back to him that although it didn't seem adequate, basic needs were one of the first things that needed addressed in crisis situations and he provided that. The participant nodded and said,

That's true and of course I know that, but that experience always stands out to me. I remember coming back from the event after my relief came in and my supervisor saying to me, "Go home and get some rest. We have a lot of work to do tomorrow." At the time I really believed that was a thoughtful statement, I still do. I think he was looking to meet my basic need in the only way he could.

I could see the parallel that the participant was drawing between his roles in crisis intervention to what he received in terms of brief supervision after the event. The participant shared,

That event, in terms of us providing support, lasted for over a week. We did a week of continuous outreach, and I will tell you at some point I really felt like I had a cut and kept digging at it every time I visited that site. It was extremely difficult, but I am proud of my part in it.

I thanked him for sharing what seemed a very profound moment for him.

I used the opportunity to ask him more about his overall experience of clinical supervision in crisis work. Informant #3 stated,

I get supervision if I absolutely need it. I am not sure how much I need at this point professionally. That's not to say I don't have new things to learn, but I dedicate time to my craft and to update myself as if I was in any other profession, so I am not sure that is his responsibility.

The participant continued sharing that supervision would be helpful if it provided him some space to deal with his emotions and make sure he is ok so that he continues thriving at his job. Informant #3 explained,

The supervisors are busy and aren't getting supervision either; if I need something I will find a way to get it. The crisis event I shared earlier is a good example. That was a tough one, ultimately he trusted me enough to continue responding. I felt like I was not in a great emotional place, but I used my team to deal with it.

The participant continued sharing that supervision may have been helpful at the time, but he has come to expect that it is not how things are typically handled. He expressed his frustration, but believed it was a systemic issue. He shared with me, "There are a lot of us; one supervisor, you do the math. It can be hard and as a more senior professional, I get it." I reflected that he seemed very aware of how the system worked and inquired about what his expectations of supervision are in crisis work. Informant #3 stated,

I wish it was possible to receive it, particularly for the younger, inexperienced crowd. It would give them an opportunity to discuss cases and determine skill level. For me, I would like some supervision for me to work out some of my own stuff so it doesn't spill on calls. I am human and no matter how long I am in the field, I still get impacted by some

things.

The participant continued by sharing that clinical supervision should be “a requirement we take seriously, but I know well enough that it isn’t and at times it is almost impossible to actually implement.” I gave space for informant #3 to talk about his need for supervision and the organizational need for supervision and thanked him for his time and asked if there was anything else he felt inclined to share. The participant paused for a moment and said,

I guess I just want to make sure that I don’t come across as blaming people for the lack of supervision. I want to be honest and tell you things aren’t great and there is a lot of room for improvement, but no one person is to blame.

I thanked him for that and reminded him of confidentiality, the purpose of the study, and the reason for seeking information about his experience. After the interview ended it really hit me that informant #3, who had been in the field for just about 5 years, appeared less frustrated and angry over the lack of support and supervision than other participants.

#### **Informant #4 Interview**

Informant #4 arrived for her interview and appeared timid and reserved in her demeanor. We started the interview and instantly it felt like I had to pull answers from her. I began the interview the same as the others, explaining confidentiality and the purpose of the study. She had no initial questions and was silent during my explanation. Although the participant appeared irritated by her experience of supervision, I had to ask more direct questions in order to help her elaborate on her experience. I asked if she would share her role as a crisis clinician. She stated, “Well, I love my job. I get to work with all kind of

people, serious mental illness or not, and problem-solve with them. There is always something new and challenging.” She appeared more comfortable after discussing her role. When I first inquired about her experience of supervision she talked about having multiple supervisors. She further elaborated, “I had a supervisor when I started and it almost felt like an abusive relationship in some weird way. Like it was bad and I probably shouldn’t have stayed, but it wasn’t so bad that I couldn’t manage.” Her use of that powerful and somewhat disturbing analogy intrigued me, because she spoke with a lot of energy that appeared to be either frustration or excitement.

Informant #4 continued, explaining that her dissatisfaction with multiple supervisors has been a constant experience in her current organization. Informant #4 explained,

A lot of times one member of leadership doesn’t know what the other members have said or done, which is frustrating. I feel like a lot of times I don’t get what I need from my direct supervisor, and I have sought feedback from my peers or other leadership in the building, and they directed me back to my supervisor to explain that I wasn’t getting what I needed.

This participant was very vocal about mixed messages as well as the system failing to ensure support for its members. Informant #4 described the experience of receiving feedback from her supervisor to address concerns surrounding her not getting consistent supervision and stated,

I did that recently and he was like “yeah, you’re right, and it’s hard to give people the attention because there are so many of you and we are always

busy.” That was irritating because that isn’t my problem, that’s a system problem.

Informant #4 seemed to understand there was a bigger issue in the crisis counseling system, but expressed her irritation that the supervisors not getting supported impacted direct care workers like herself. The participant stated, “That was irritating because that isn’t my problem, that’s a system problem. The truth is why would he feel comfortable giving me feedback or helping me not emotionally respond to calls when he barely knows me?” This participant talked a lot about taking responsibility to ask for supervision to get what she needs. I inquired about her expectations for supervision and she replied, “Well my first expectation is that it would happen weekly and it never has in all the years I have been here. Never. Honestly, I would like them to meet the need for supervision just in terms of that at this point.” Informant #4 expressed frustration over the system’s inability to meet the basic need for supervision.

I listened to the participant share her disappointment over not getting the support she felt she needed and was struck by her ability to continue coming into work at a place where she was not sure people really understood the work that she was doing at the agency. Informant #4 shared, “I go and get what I need, but I know I’m missing clinical and professional growth without supervision. Things don’t get addressed, and then they build up and I see it spill into my work.” This statement really hit me because there was a clear indication for this confident clinician that things were spilling into her work because of the lack of support. This participant spoke about the time she spends working and how it consumes everything. The participant said,

We work 8-hour shifts and end being here for at least 10 several times a



week. On Friday I work 9:00 to 5:30 and I know I won't leave this building until 9:00 because Friday's are crazy. He never [my supervisor] even asks about all of the overshift and how drained I feel because of it; it's just the nature of the job.

Throughout the interview informant #4 did not appear to be complaining, she was stating facts surrounding her experience. I suggested the notion of being set up to fail before she comes in the door knowing that it might be an emotional day and she will be working longer than an 8-hour shift. I shared with her that it sounded as though the organization was in crisis mode itself, as it was managing the moment rather than the bigger picture and how it impacts staff. Informant #4 stated, "Yeah, and it's like you are last on that list. Everything and everyone comes before you." That statement was very powerful, particularly because she is going out into the community and serving the direct needs of people who are facing disasters. Informant #4 continued by saying, "When you said we are in crisis mode, it is true I am always in crisis. I don't know how to step out of that role." The participant continued by sharing a story in her personal life where she stepped into the crisis clinician role:

I was at a wedding last weekend and there was a guy there who was pacing back and forth down the aisle before the ceremony. I felt like I had to step in because it could have turned into a huge scene, but seriously what is wrong with me that I can't be a normal attendee and go to someone's wedding without doing an intervention? It's like I am wired to never stop and I feel like that is reinforced at work. I can't turn it on and off and it takes over my life sometimes. We don't even get supervision in

order to turn it off.

Informant #4 spoke about not knowing how to take a break from her work because she has never had the opportunity to really disconnect mentally or emotionally. I inquired how that inability to disconnect impacts her daily work. She said,

It's hard to be fresh. I have a hard time taking each call as brand new, because it feels like one long crisis call. It's Groundhog Day, which is kind of interesting because I always tell people one of the things I love about my job is that I come in and never know what my day is going to look like. At the same time it can be tiring.

As the interview continued she voluntarily shared with certainty, "It's also the greatest job I have ever had." I did not prompt that response; she provided it on her own and said it with absolute certainty.

In her discussion of the positive aspects of her job, she identified the value of working with her team, "We are on our own, many of us feel that way. It is why we have such a sense of camaraderie. We have each other's backs at the end of the day." She talked about the sense of team keeping her sane when there are tough moments or days. This participant shared a difficult call she experienced with an infant and talked about no one checking in with her other than her team. She added, "That is a lot to carry." It appeared she felt that checking in with her team helped her get to a better place, but she would have appreciated a supervisor stepping in to discuss the case and her feelings. Informant #4 shared, "I would first make it mandatory to actually sit down and meet. Sit in like, an office, not the hallway or the parking lot where we happen to run into one another. I mean that's nuts. We need time for supervision." I inquired about what she felt

was needed for supervision and her first response was simply time for it. She elaborated and talked about cases and team supervision and shared, “I would like for people to acknowledge the lack of self-care and help me identify when it’s an issue because ultimately I am in clinician mode and I can’t see myself that way.” I was grateful for this participant who was so open and honest about what was and wasn’t happening for her in role as a crisis clinician. Like others, she was appreciative of time to vent and release some of the frustrations in a safe place.

### **Informant #5 Interview**

Informant #5 showed up a little late to the interview as he had been working. He entered the room, appearing calm, and seemed unsure where to sit. He chose to sit a couple of seats away from me and waited to begin the interview. The participant described his role, “I can be a listening ear, a provider of resources, a mediator, or a collaborator. It’s a rewarding and exhausting job.” Informant #5 discussed the flexibility needed for effectiveness of his job. He said, “You have to bend yourself to fit whatever situation you walk into, you know? It requires you to adapt to whatever is happening and be ready to respond in an appropriate way.” Even in his description that required him to wear many hats, he appeared happy with his role and spoke highly of the work he does. I noted this to him in the interview, and he commented, “I know when I go into work that day I am needed.” We talked about his value at work, and the participant shared that he felt valued and felt content in comparison to other jobs he has held. Informant #5 appeared comfortable and direct in his responses.

He talked about receiving brief supervision in both frequency and length, but felt it was a larger systemic issue rather than the supervisor not doing his or her job.

Informant #5 stated, “You know supervision is a rare commodity. I get it, in quick spurts, you know check-ins. Everyone is so busy, including them, that really doesn’t, it just doesn’t allow for time for supervision across the board.” The participant appeared understanding of the pressures placed on supervisors that might be inhibiting them from doing supervision with the staff. The participant discussed that his most recent supervision involved his employee review, which happens annually at his agency. He shared, “We have reviews; you know yearly, to make sure we are keeping up with all the requirements of the job.” The informant explained that discussing an annual review of staff is a requirement of the job. In discussing his the annual review of skills and abilities the participant shared that his peers would be the better evaluators given that they see his work.

Informant #5 appeared to be working through his understanding of supervision throughout the interview. He said,

I mean if things were really bad then maybe I would need more supervision. I know as a supervisor myself that I tend to pay more attention to the ones who need help, so the fact that I am not getting as much attention is a sign that I am ok.

Informant #5 appeared to make sense of the lack of supervision to mean that he was doing his job and did not need as much as newer or less experienced staff. This participant had supervisory experience at another agency so he interpreted his supervision the way he provided it at his previous job. He shared, “I know as a supervisor myself that I tend to pay more attention to the ones who need help, so the fact that I am not getting as much attention is a sign that I am ok.”

Ultimately, the participant seemed to feel that if something was really wrong or needed attention that a supervisor would have pulled him in to discuss it. Informant #5 talked about the sense of team and bonding that occurs in crisis work. The participant disclosed,

And you know crisis is set up in teams. So you are never alone in that sense. Like if I needed something the best people to go to would be my partners anyway, because they know me and my work much better than any supervisor anyway.

The participant appeared very confident in his interpretation and spoke very highly of the facility he worked in and the job he was asked to do on a daily basis. There was a sense of pride that he exuded and filled the room during the interview. Upon reflection to the participant that peer supervision seemed to be helpful he responded, "I know how busy the supervisors are. I get it. I mean the system is not set up to support itself at all. That isn't a judgment, that is just a fact. I mean the supervisors aren't getting supervision either." Informant #5 was clear that the overarching system was the biggest issue because no one was getting the full support necessary throughout the agency. I inquired about what supervision expectations would look like for him, and the participant seemed caught off guard by the question. I gave him a moment to gather his thoughts, and he stated, "I guess ultimately supervision should include team supervision, case reviews, and probably some self-care stuff." He talked about the different aspects in crisis thus making the idea of providing supervision a challenging one. The participant stated, "I mean I think crisis work is so hard to supervise because there are so many components." I asked for some more clarification regarding self-care, initially surprised that he had brought it up himself.

Throughout the interview he gave off the impression that everything was manageable because of the strong fabric of the crisis team. He proudly commented, “Well we are a crew of workers. Hard workers. We stay late come in early go from call to call. The calls aren’t easy and sometimes it might be nice for supervisors to check in and make sure we are ok.” The comment caught me off guard because it didn’t seem to line up with the theme of the rest of the interview. This participant had been in the field the longest and also had another perspective given that he had previous experience as a clinical supervisor at other jobs in the mental health field. I thanked the participant for his time and the interview ended.

#### **Informant #6 Interview**

Informant #6 arrived for her interview and needed little prompting to engage or elaborate responses. She had a lot to share and was very passionate about her work. She entered the room and expressed her eagerness to be a part of a study on crisis. I asked the participant about her role at work and at first she went on to describe the details. The participant described, “My role is to go out and assess the situation to determine what each individual in crisis may need. We might be facilitating hospitalization or linking to resources or someone to talk to, it really depends, you know?” She talked about the hats she wore and how each crisis presented a new challenge. After she explained her role in technicalities she stopped and stated, “It’s fun. I never knew jobs like this existed. I am important and help people who can’t see solutions . . . that is why I went into this field, to help and make a difference.” Informant #6 talked about her work in crisis almost as if she saw it as a calling, something she was meant to do. I reflected back to her that she seemed very invested in her work to help, and she elaborated, “The need to help, the want to help,

that's in me." The participant valued her role and the work she did in crisis and wanted to make sure that was clear in the interview. She shared,

I am important and help people who can't see solutions . . . that is why I went into this field, to help and make a difference. I do that, that's something I can be proud of, so yeah, that is what I do.

The participant talked about the shift work and how difficult it can make the job. She said,

All the research says something like shift work is so bad for you and impacts all these areas of your life in a negative way and here we all are working shifts in crisis no doubt. Which is more than shift work. I mean we work late almost every day. It's not like I can leave at 5:00 'cause my shift is done . . . if I'm on a crisis, and the crisis is still going, then so am I. You give up something working in this. Your whole family gives up something.

She also discussed how the shift work was a good benchmark for her to realize just how much she loved her job. The participant shared,

We want to be here and we keep coming back. I worked 'til 3:00 a.m. on Monday and came in for a 10:00 a.m. shift the next morning. I got a few hours of sleep and was back at it. A lot of us do that. And I think that speaks volumes. I mean it's not the healthiest. I don't know if like all the bosses know we do that, but it's real. It happens all the time. Someone has to be there.

She talked a lot about her team and them being there for her in difficult moments. Even at the end of tough days the participant shared that she kept going because she realized there was a bigger picture and she part of something special. Informant #6 stated, "Don't get

me wrong there are days you walk out dead tired. Your body feels it because your emotions go through the ringer. But most days you walk out proud. I am a part of something so much bigger.”

I inquired how the participant kept herself together after being emotionally and physically exhausted from the calls as well as the shifts and she seemed to have a simple answer that in reality required constant self-awareness. Informant #6 shared, “Self-check. Constantly. I mean I lean on my team.” The participant tried to keep track of her emotions and make sure that her partners were looking out for one another on certain “red button” issues, as she called them. The red button issues she identified are things that might trigger something in her because of her own unique experiences. Informant #6 commented, “We go call to call so the call I got at 8 a.m. is still with me at 2 p.m. and I have to be together and so does my partner. That’s why team is everything.” She spoke highly of her team and seemed to appreciate the special bond that occurs in crisis between her and her team. She shared, “We are tight but together a lot. So you know, dysfunctional family sometimes.”

I inquired about how the participant deals with all those stressors and she talked about her life a little outside of crisis. She discussed that she has a child and tries her best to keep up with that life, but in reality it is a lot to carry. The participant said,

I mean I have a little kid and kid calls can be rough. You hate to see someone suffering or a parent doing something stupid and dangerous. I gotta constantly watch myself for getting sad, angry, frustrated, anxious, because that can ruin a call and impact safety, too.

Informant #6 appeared aware of the potential of her personal life and experience



conflicting with crisis calls. I suggested that it might be difficult to handle challenging calls and then go home and be attentive to her parental duties. I asked her what she did with all the leftover emotion from the day. She said, “Swallow them. I got a kid and a life that I have to be present for and there is no time for work to get in the way. I don’t always succeed at that. Actually I fail a lot.” Informant #6 eyes watered as she said this, and it appeared to be something that is still difficult for her.

I inquired about her experience of supervision and she said, “Well supervision here is sort of in the moment.” Informant #6 discussed that supervision was something that happened briefly and rarely. The participant shared a realization that seemed to come to her as she was speaking about the evaluative component of supervision. She talked about her supervisor being responsible for evaluations that include her skills and wondered how well her supervisor is actually able to do that without meeting with her often to actually discuss those skills. Informant #6 shared,

I mean I like my supervisor just fine but it is kind of crazy ‘cause those are the guys that evaluate you for like salary increase and stuff and they probably know really little about me. That’s crazy to think about. But I guess I’m doing alright if I haven’t been pulled in or anything. Like I guess I know what I am doing for the most part because otherwise they would tell me.

The participant talked about never getting in trouble or having a supervision where she was doing something wrong and seemed to associate the lack of supervision with the fact that she must be doing her job well. Informant #6 discussed the significance of her peers in assisting with evaluation and support of her skills, “Supervision is

important, but I also know that I count on my team for the things I would want in supervision.” As the interview continued we talked about what her expectations of supervision would be and she shared, “Yeah, I mean supervision would be helpful if I had someone to like debrief with. We deal with some hard stuff.”

Informant #6 talked about a difficult case involving the death of a child at the hands of the child’s mother and as a new mother herself she found herself struggling to remain present. She used that case as an example of how supervision might have been helpful to work through some of those powerful emotions. Informant #6 stated,

I had this one case where the mother smothered her baby. I had just had my son, and here I was trying to talk with a woman who had done this to her child. It broke my heart and angered me to a level I can’t even tell you. I remember trying to stay silent for most of it and let my partner handle the majority of the call. I was disgusted. I could have used supervision then, to just talk and deal with it. There are a lot of calls like that where it would be nice to have some space to really talk and deal with some of those emotions.

In the interim she discussed using her partners to help her check-in and make sure things were ok. It struck me how much pressure and responsibility there seemed to be for the partners who are also dealing with their own emotions and experience. As the interview concluded it appeared that informant #6 questioned the purpose of supervision and recognized how supervision could better meet her needs. She said,

Some face time. You know those check-ins or whatever we do to touch base it’s just, it’s not enough. The supervisor grabs you in the hall or

something and wants to do this quickie supervision so you feel kind of cornered and you can't think of the million things you know you want help with in that moment.

The interview ended and I thanked her for agreeing to be part of the study. She said she was glad to be a part of the process.

### **Informant Interviews and Lived Existentials**

I used Van Manen's four lived existentials as a lens to further investigate the lived experiences reported by the informants in the interviews and focus group. The resulting transcriptions were reviewed and the data categorized in accordance with the four existentials of spatiality, temporality, corporeality, and relationality.

#### **Lived Space (Spatiality)**

Lived space, or spatiality, refers to the way we feel or react to the space around us as well as how we may impact the space (Van Manen, 1997). Informant #1 identified, "Sometimes you can get claustrophobic and it's hard to breathe because suddenly everything gets a lot smaller when you are the center of attention and people are expecting you to do something, you know." Informant #1 reflected on the space and how it impacts her and her partner when they are called in to a crisis call. She referred to lived space as closing in on her because she felt that everyone looked to her for a response and a decision. Informant #3 commented, "I might sit in his office, which almost feels awkward because there is no real relationship other than maybe mutual respect. The space can feel a little odd, but we also don't talk about much." The remark shared by informant #3 speaks to his feeling about sitting in the office with the supervisor and reflects how strange the space around him feels due to limited contact with the supervisor.

He was aware of the space around him. Informant #6 expressed, “The supervisor grabs you in the hall or something and wants to do this quickie supervision so you feel kind of cornered and you can’t think of the million things you know you want help with in that moment.” The description of space by informant #6 was vivid to her as she remembered feeling closed in in an area where she was not used to having supervision, which limited her ability to respond the way she had wanted. The space described by the informants was significant to them and the way they made sense of those moments whether on crisis calls or in supervision.

### **Lived Time (Temporality)**

Lived time is how we experience the passage of time instead of factual time. Our experiences can alter our perception of perceived time, which adds significance to the meaning of that moment for individuals. Informant #1 addressed the concept of her experience of time, stating,

I mean it would be nice for supervision to last more than 10 minutes. You know those little check-ins or whatever, time blows by and you’re thinking to yourself like what just happened? I was going to share all these different things but time just got away.

The participant’s explanation of time coincides with one of the emerging themes of the interview of *supervision in the moment instead of one-on-one debriefing* and indicates how important the amount of time spent in supervision impacts the perception of quality.

Informant #2 shared,

It’s annoying because when a supervisor stops you in the hallway or something and is like hey that case did you remember this or that and I

feel like that is such a missed opportunity. Like take 25 minutes and sit with me.

Informant #2's description and understanding of lived time speaks to his feeling of not being a priority in the eyes of the supervisor. It also corresponds with the theme of the crisis teams and supervisors *operating in crisis mode*. Another important reflection of time from informant #2 was in regards to the actual crisis calls, "We were there for like 3 hours, or at least it felt that way!" Informant #2 describes time passing quickly with supervision when he feels as though he needs more time and describes time passing slowly on a crisis call. Conversely, informant #3 talked about the time spent in supervision as slow, stating,

It's like those movies when the kids are in the last class of the year and it ends at like 3:30 and all we see is the clock ticking slowly and everyone waiting for that final tick so they can get out there.

Informant #3 discussing the slow passage of time as he experienced it in supervision directly related to his perception that he and the supervisor have no relationship, and so there are a limited number of topics that can be addressed. Similar to informant #2, informant #4 identified supervision being too quick, and therefore lacking productivity. Informant #4 shared, "I mean what can honestly be addressed in 15 minutes?" The participant's question of how much can be handled in that short time span speaks to informant #4's experience of supervision not having dedicated time to spend working on cases, skills, or self-care. Informants #5 and #6 seemed to share the more common view that the passage of time moved very quickly due to the business of the system. Informant #5 commented, "You know supervision is a rare commodity. I get it, in quick spurts, you

know check-ins.” Similarly, informant #6 expressed, “Well supervision here is sort of in the moment. We are always on the go so it feels like its 10 minutes here or 5 minutes there.” Temporality was a theme that came up in each interview, as it coincided with the participants’ experience of how their time is spent versus who spends time supporting them.

### **Lived Body (Corporeality)**

Van Manen believed that the lived body was significant because it addressed the way in which our bodies and all five senses experience and interact with the world (Van Manen, 1991, 1997). The interviews demonstrated that the crisis clinicians chosen for this study experienced their world in many different ways. The idea of corporeality was threaded through multiple experiences in the language used by the participants. When describing a difficult crisis event, Informant #1 expressed, “I just felt sick. I carried it with me everywhere I went, literally felt it lingering in the pit of stomach.” Informant #1’s experience of some emotional triggers was embedded in her physically. She refers to this burden as something she had to “carry” with her and also something that was within her, part of her so that she was unable to escape it. It spoke to how powerful and all-consuming that event was for her. Informant #3 shared a similar experience regarding a crisis call that he was describing, “I remember feeling sick and like that feeling you get when your heart is in your throat and you just keep swallowing, or gulping rather so you don’t lose it. Yeah, I remember that well.” Informant #3’s vivid description of his experience and how it encompassed his body was prominent as he relayed the lack of support he received after that powerful incident. Informant #4 shared a slightly different experience of physical exhaustion rather than just emotional exhaustion, “He never [my

supervisor] even asks about all of the over shift and how drained I feel because of it, it's just the nature of the job.” Informant #4 explained that her body was physically so exhausted from just the hours alone that it was unfortunate that no one, particularly her supervisor, seemed to notice or address the issue. Feeling physically capable of doing the job provides a better opportunity to manage some of the emotionally draining experiences throughout the day. Informant #6 directly talked about her body and her experience during a trying crisis event, “Your body feels it because your emotions go through the wringer.” Informant #6 shared that her mind and body feel it when she continuously goes from call to call without support. Many of the experiences of lived body directly relate to the emerging themes of *emotionally and physically exhausting crisis calls/events* as well as *always in crisis mode, struggle to disconnect from work*.

### **Lived Others (Relationality)**

Van Manen's lived relation (others) was the most prominent existential in the interviews as well as the focus group. *Relationality* refers to the lived connections we make and maintain with others (Van Manen, 1991, 1997). Informant #1 talked about a need for a connection with her supervisor, “I don't think I am a lost cause but I need support.” Informant #1's need for support refers to a need for some relationship with the supervisor in order to feel connected to something outside of the crisis work in order to help her make sense of things. Informant #2 similarly shared, “I would like for my supervisor to know me; I mean that would be the first step. For them to know us the way we know each other. If there was a relationship it might be easier, you know?” Informant #2 identified that without the relationship it is a struggle to have the professional development and support that is needed. Informant #2 valued relationships, stating, “It's just nice to know

there are people like you who get what it is that we do. Makes you feel like you have a crew, you know what I mean?” Informant #2 felt like the connection to others was something that made him more comfortable and less isolated. Informant #4 shared a similar experience in regards to supervision: “The truth is why would he feel comfortable giving me feedback or helping me not emotionally respond to calls when he barely knows me?” Informant #4’s comment indicated that the supervisor’s inability to get to know her made it difficult to provide feedback, whereas she felt that connection with her team and partners who were able to consistently provide support and feedback. Informant #4 talked about her team, stating, “It is why we have such a sense of camaraderie. We have each other’s backs at the end of the day.” The relationships developed in her line of work enhanced her experience and kept her grounded in the work. Informants #5 and #6 identified connections with their team as one of the most important things about their work. Informant #5 expressed, “And you know crisis is set up in teams. So you are never alone in that sense. I mean we see some really difficult things together so we are bonded by that if nothing else.” Informant #6 shared, “I mean I lean on my team. I love my team. That’s why team is everything.” All the participants shared significant statements regarding their team and partners, identifying that as the outlet that has made the lack of relationship and support in supervision bearable. The participants’ experience of lived relation relates to the themes of *strong sense of team and partnership/bonding among clinicians* as well as *supervision is a system problem because supervisors aren’t getting supervision either*, referring to a lack of relationship throughout the many layers of the system.

### **The Focus Group**



A focus group is a method of qualitative research that is designed to encourage participants to talk to other group members and respond to questions or prompts about their perceptions, beliefs, experiences, and attitudes about a service, product, or concept (Lindolf, 2002; Rossman et al., 1999). I used a focus group in addition to the semi-structured interviews to validate the themes that I gathered in the one-on-one time I spent with the participants and to invite the informants to elaborate and share more of their collective thoughts and attitudes about clinical supervision in crisis intervention.

### **Synthesis of Themes**

Prior to conducting the focus group for this study I developed an initial list of themes that emerged from the interviews with the participants. The first time I listened to the audio recordings of the interviews I transcribed them. After this process, I listened to the tapes again and noted any tone or emotion that I did not catch during the transcription. Using Colaizzi's (1978) method of inquiry I read through each of the individual interview transcripts; I read and reread them to ensure that I had a solid understanding of the overall content of each interview. I then read through the transcripts again to highlight key words and phrases that stood out to me as thick description of the phenomenon—the participants' experiences with clinical supervision. I read through the statements and connected them with their appropriate lived existential according to Van Manen. I used multicolored highlighting in order to categorize the statements that pertained to the phenomenon. I used a separate piece of paper to record the phrases and words that pertained to the phenomenon and listed them with their page numbers so I could track the information back to the transcription and see the context of the description of each lived experience.

As a result of the analysis of the interview data, I identified phrases and words that continuously came up when the participants described the meaning of supervision and categorized them into themes to present in the focus group for further elaboration and validation. After listening to the interviews and writing down statements from the participants that stood out, I attached a formulated meaning to the statement along with how they fit with Van Manen's lived existentials (Appendix I). After I attached formulated meanings to the statements from the individual interviews, I attached theme clusters and emergent themes to the formulated meanings (Appendix J). The emergent themes in the following list were the themes I presented to the focus group (FG).

#### **Themes from Individual Interviews**

- **Collective sense of pride and passion for crisis work** (*pride and passion for crisis work*)
  - Clinicians were generally very enthusiastic about the work they did.
  - Generated a lot of excitement while discussing their role.
- **Value in the work that is done on a daily basis** (*value in the work*)
  - Clinicians generally identified that they were “meant” to do this job.
  - Clinicians believed that their role was important and made an impact.
- **Strong sense of “team” and partnership/bonding among clinicians** (*sense of team in crisis work*)
  - Trust and comradery among partners and team.
  - Feedback/peer supervision existed among the team.
- **A job that requires constant flexibility** (*flexibility needed in crisis work*)
  - Clinicians go from call to call.

- Clinicians describe their job as wearing many hats and doing whatever the situation requires.
- **Emotionally and physically exhausting crisis calls/events** (*emotional and physical exhaustion from calls*)
  - Some recalled specific incidents that were challenging and draining.
  - Clinicians generally discussed the need to be completely present for all-consuming crisis calls.
- **Always in “crisis-mode”; struggle to disconnect from work** (*constant crisis mode*)
  - Due to the intensity and volume of calls clinicians found it difficult to separate from being a clinician.
  - Many described “carrying” calls with them after work.
- **Countertransference on calls, calls that trigger clinicians** (*countertransference*)
  - Clinicians identified feeling vulnerable at times during certain crisis events that triggered the clinicians.
  - Clinicians identified emotions and experiences “spilling” into crisis calls where the consumer should always be the focus.
- **Supervision occurring “in the moment,” not a sit-down debriefing** (*supervision in the moment*)
  - Clinicians talked about brief moments with their supervisor regarding certain situations, but no time to sit one on one for an hour and have clinical supervision.

- **Lack of supervision leads to questioning skills and professional development**  
*(lack of supervision makes clinicians question skills)*
  - Clinicians discussed their skills declining due to lack of supervision.
  - Clinicians identified a lack of growth, professionally and personally, due to insufficient supervision.
- **Lack of supervision reflects that there is not as much need for supervision**  
*(lack of supervision means clinicians are doing well because supervision is for those who struggle clinically)*
  - Clinicians identified the supervisor only focuses on people who need more assistance.
  - Clinicians discussed the lack of supervision meaning that the clinicians' skills were ok and no feedback was needed at the moment.
- **Supervision expectations include self-care, professional development, case consultation, and team building** *(supervision for self-care)*
  - Clinicians identified that it would be nice to have supervision to discuss cases, grow in skills, check-in on well-being and the emotional baggage that might result from a crisis and team supervision to work with partners better.
- **Lack of supervision leads to questioning about evaluative component of skill development and progress** *(evaluation in supervision)*
  - Clinicians identified that part of supervision is to identify skills/competencies and evaluate clinicians' progress.
  - Clinicians challenged how this could be done fairly without regular

supervision and monitoring of skill development.

- **Supervision is a system problem because supervisors aren't getting supervision either** (*supervisors not getting supervision*)
  - Clinicians shared that because of the nature of the work everyone is busy and not getting supported from their supervisor, including supervisors.
  - Systemic support is not happening because the system is operating as crisis clinicians, managing the moment and not the root of the problem.

I brought the emergent themes to the focus group for discussion. After all the participants arrived I began the group by reminding everyone of confidentiality and the purpose of the study (Appendix H). After I reinforced confidentiality and asked that everyone sign the separate consent form to participate in the FG, I talked to them about the focus group process. I explained to them that after reviewing the transcripts and listening to the tapes I identified several relevant themes that seemed to emerge from the interviews. I explained that the participants' names were not included, nor were there direct quotes that could expose their individual identity or violate their confidentiality. I informed the group that the FG was to be a discussion and that my role would be to convene the group and to observe the interactions and dynamics of the group. I reminded them that this interaction was being audiotaped and that I would be taking notes and occasionally making comments to focus and clarify the discussion. The group sat in a circle of desks together while I sat outside the circle, so that I was physically not in the group and not a direct influence on the participants. I provided each group members with a list of themes (Appendix K) and explained that I would ask questions for clarification, but mostly wanted to the group to run the discussion. I asked if someone would start by

reading a theme out loud for the group and that they could take turns on who read the themes as the interaction continued. The group appeared open to the idea and understood the concept of what we were trying to do.

The group was made up of the six informants who had participated in the individual interviews. They worked for two different crisis response agencies in Western Pennsylvania. Informant #2 and informant #5 shared a supervisor; all other participants had different direct supervisors. In the beginning of the focus group discussion, informant #5 took the lead by reading the theme and providing his thoughts on it. I was concerned that this participant might dominate the leadership role in the group; I did not want the group to have a leader in order to make it a group of equals having a discussion. I was interested in hearing how they collectively agreed or disagreed with the themes that I had identified from the interview results. Although informant #5 took the initiative to speak, he was soon joined by informants #1 and #3 and eventually the rest of the group. The themes were read in the order they were presented on the paper by informant #5, who volunteered to read them for the group.

Overall, the group needed very little encouragement or direction, because the themes discussed were generated by them and represented shared experiences that each member had in crisis and clinical supervision. They appeared familiar with the themes, and they inspired a lot of emotion among the group members. People within the group responded enthusiastically to the themes and, for the most part, to one another. One participant, informant #5, appeared to be more of an outlier, as he shared a different perspective than the rest of the group. Informant #5's presence in the group and his opinions appeared to invite the other participants to be more vocal about their thoughts

and feelings. Informant #5 seemed to evoke and stir emotions for other members, particularly when talking about supervision and teamwork.

As the focus group proceeded, group members quickly found alliances with one another over their shared meaning of their experiences. I observed the process and paid attention to content, but was more focused on reaction and interaction among the group members as they discussed the themes. The group addressed each theme individually and shared their experience and interpretation of the theme.

The first theme addressed by the group was *pride and passion for crisis work*, and it appeared to be an effective opening topic that invited all participants to ease into the conversation. The participants were all in agreement that there was something special about the work that excited them and motivated them to keep doing it. Informant #5 commented,

I really love the work and feel excited talking about it usually. People at my agency always refer to us as the “cocky group,” and I take that as a compliment because we are confident in what we do and we are good at it. All other participants appeared to agree with informant #5 and added comments of their own to voice their agreement. Informant #3 added,

At our place people think our teams are “tough” but you know we have to be because we are there in dangerous situations and we are tough but good. I mean we keep coming back, I keep coming back so, yeah passion and pride make a lot of sense.

All participants agreed that there is a confidence that is not necessary but is helpful in crisis intervention work.

The second theme addressed by the group was the *value in the work*, referring to clinicians having a feeling that they were meant to do the work. The group agreed on this theme's meaning and seemed to concur with the implication that they are a special population to be able to manage the things that they do. There was some clarification among the group that this meant no one else could do the job like them. Informant #6 shared, "I was meant for this and no one else can do it like me." Other participants shared this idea of value. Informant #5 stated, "I don't know about fate, but I do know that the work I do is important. Like I don't work in retail where no one remembers me being there." Other participants in the group took a softer stance, recognizing that other jobs had value, too, but agreeing that the work they did was valuable. Informant #4 said, "I mean I think all jobs have value. I'm not sure how comparable it is but it's hard for me to picture doing anything else." The group seemed to handle this slight difference ok and nodded their heads along with informant #4.

The next theme discussed was the *sense of team in crisis work*. Informant #4 stated, "Team is everything. Without my partners I don't know if I could actually do the work." The other participants seemed to identify with this statement, as there was head nodding and other participants' confirming her comment. I interjected at this point because it seemed as though the group was simply agreeing with themes rather than discussing meanings and experience. I inquired as to how the sense of team was important to their work. The participants appeared to have an overall sense that the team is what kept them grounded. Informant #2 shared,

I feel like for me I mean with confidentiality and everything it's important that I have my team to debrief. I mean when you want to cry or punch



something after a call that really struck a chord, your partner gets it. And they care.

Others appeared to be in agreement, and informant #5 added, “Team is what makes the ship run.” It seemed that the group felt the challenging work they did was more manageable in a team with a partner who can be trusted. Informant #1 identified that the focus group had formed a team in the discussion so quickly because of their common experiences.

Another theme addressed in the group was the *flexibility needed in crisis work*, and the group seemed to confirm this theme. Informant #3 said, “I don’t just have to be flexible, everyone involved with me has to be flexible.” The other participants talked about the need to live in grey areas and that concrete thinkers tend to struggle in crisis. It was interesting to hear the group all in agreement in this area because they discussed the theme as it impacted them in a negative way. Informant #2 stated, “It’s a little frustrating honestly, because you can lose your identity. You have to be a chameleon and change with the setting.” Informants #3 and #6 both nodded their head in agreement. Although participants had minimal reaction to the statement, it struck me as profound that extreme flexibility makes them so adaptable yet sometimes it made them feel like they may not have their own identity. The interaction continued briefly, and informant #6 shared, “You know it’s kind of interesting to, because like, um, you have to be flexible for your own safety, too.” The conversation around flexibility seemed to create a different energy in the room, as it appeared to create some frustration, whereas the theme prior seemed to leave the group feeling more at ease.

The next theme addressed by the group was *emotional and physical exhaustion*

*from calls*, and it evoked an abundant amount of engagement from the participants.

Informant #6 spoke first to this theme stating, “If someone asked me I could probably describe in detail several crisis calls that are still with me.” Several participants agreed with this statement, and it seemed the group took a minute to think this theme over and determine how to contribute to the conversation. Informant #4 said, “I have felt sick to my stomach after some calls. Sleepless nights, the whole nine.” The participants were fairly quiet during this theme and provided minimal detail regarding any specific calls. In the interviews, each participant shared without prompting their stories about good and bad calls. In the focus group setting, members appeared more reserved in this area. During the discussion of this theme, teamwork and supervision were both brought up as answers for emotionally or physical draining calls. Informant #3 stated,

I mean to be able to really talk about those calls with a supervisor would be so helpful, even a couple of minutes. It’s like I have nowhere to put it until I talk it out and so I have to hold on to it.

Another participant commented that those emotions were best shared with the team. Informant #5 took the first step in a different direction in the group, stating, “Again though, I think that I could pull the supervisor if it was so bad but it might take more time to explain the situation, which wouldn’t be productive.” The conversation seemed to imply that repeating the story would take more time and energy that staff at a crisis agency does not have in order to seek support or relief.

Another theme discussed was *constant crisis mode*. The participants seemed to take this theme in stride as something that was just part of the job description. Informant #4 said,

I totally agree with being jaded. I have a morbid sense of humor as it is. I get told all the time that I can be harsh by my family. But like if you don't develop a thick skin you can't survive.

The business of the schedule and the nonstop environment had created some mental toughness that the group saw as an essential quality of a crisis clinician. The participants seemed to agree that the whole system was in crisis mode and that the experience of being in that crisis climate was contagious. Informant #6 shared, "I think the thick skin is necessary; it would also be nice every once in a while to be human." Other participants seemed to echo this sentiment that it can be tiring to keep up with a constant nonstop pace.

The next theme addressed was *countertransference*, and the group seemed to naturally gravitate towards this theme as they discussed always being in crisis mode. For the group this theme meant that they were not successful at their job. The group made sense of countertransference as something that interferes with the intervention and has a negative impact on the consumer. While some group members could identify that they might have some moments of potential countertransference, many participants justified that countertransference is inevitable in everyone and that it's unlikely it would negatively impact the call or the consumers. Their meaning of countertransference seemed to create discomfort among the participants, who at all other times during the focus group demonstrated confidence in their work and abilities. This theme seemed to draw a divide among the group, as there were some different experiences and opinions. Informant #1 shared, "I want more than anything truly to say nothing of mine has spilled onto calls but I know that is not true." Other participants commented that they did not

feel any potential countertransference that they have experienced was bad. Informant #5 commented that no countertransference could be too bad because partners would address it. Informant #1 shared that was a lot of pressure for partners to be paying attention to all the nonverbal and verbal interactions of both the clients and the clinicians. Many of the participants seemed to attribute the meaning of “partner” as someone who was a peer supervisor. The group trusted and relied on their partners to not only serve as a different perspective on an intervention, but also to maintain safety and keep the other partner in check clinically. The group appeared to be actively engaged in this debate. Informant #4 shared,

I think countertransference can happen to both of us on a crisis call and if that is the case then we’re both screwed because no one is aware enough to make a judgment. That has to happen in supervision and it doesn’t.

The comment quieted the group and they slowly transitioned to the next theme. It appeared some of the group was very protective of the work they do and admitting to countertransference seemed to diminish the value they hold on their work.

Another theme addressed by the group was *supervision in the moment*. Informants #5 and #6 talked about brief supervision occurring because everyone was too busy for lengthier, more focused supervision. They said that they understood the reason for quick supervision, as opposed to a more comprehensive approach, because the system, the crisis intervention system, would not be able to support clinical supervision. Others in the group disagreed and seemed frustrated at the inadequate amount of time given to supervision. Informant #2 shared,

I once complained to an old supervisor I had that I never got supervision

and she was like, “your problem is you don’t know what supervision is cause you get it all the time. Those moments when you ask me something about a case or the 5 minutes we spend in the hall, that is supervision.”

The participant discussed his irritation that a supervisor did not seem to value or understand the purpose of supervision, comparing it to 5 minutes of time in the hall.

Informant #1 shared a similar thought, “Like supervision happens and you have to soak it up. Like have I missed it? Isn’t it supposed to be a sit down conversation?” The group was not all in agreement with informants #1 and #2; others felt that some valuable things could happen in a few minutes of “hallway supervision.” Informant #5 stated,

They’re tied up so, you know. Like with their own stuff. Totally tied up and asked to do a million things. That is why I try to take responsibility because I know it’s not physically possible for them to do the sit down debriefing. I think supervision can happen in a few minutes if you are open to receiving it that way and depending on the level of your skill.

This comment by informant #5 stirred emotion within the group because some participants appeared to think he was defending the supervisors for not doing their job. Informant #2 said, “Yeah, but so then you are saying supervision is for people who suck at their job.” Informants #1 and #3 supported that statement and seemed to be upset by informant #5. I observed informants #1, #2, and #3 making side comments to each other and shaking their heads as the conversation continued. Informant #4 attempted to stay neutral, stating, “I can see both sides. I mean think about teaching. If you do what you are supposed to and turn in your stuff the teacher doesn’t keep you after class. They keep the students who are struggling.” Other participants openly disagreed with that theory of

supervision. There was a lot of disagreeing in the room, and I left some space for the group to talk about the meaning of the issue. After more conversation, informant #5 continued to defend supervisors, which appeared to bother the other group members. Because opinions varied and the conversation was not leading to a consensus, I took the opportunity to interject and help the group shift focus to the next themes.

The next two themes were discussed together: *lack of supervision makes clinicians question skills* and *lack of supervision means clinicians are doing well because supervision is for those who struggle clinically*. These themes address the purpose and function of supervision as seen by the crisis clinicians. These themes were generated from the clusters of formulated meanings because some participants believed that the fact that they were not receiving consistent supervision meant that they were doing well at their job and there was no need for supervision. Other participants felt that by not receiving supervision they were not only losing skill development and enhancement, but also confidence in their clinical ability to manage a crisis. Both of these themes generated more tension among the members. Informant #2 spoke first as he appeared to feel strongly about these themes. He said, “I, um, I sometimes feel like I am not as good as I was because of the lack of supervision I’ve received.” Informant #1 strongly agreed with the statement that lack of supervision was frustrating and left her questioning her abilities. Informant #5 shared,

I’m not saying you never grow or learn. I’m just saying you find other ways to fulfill that need. The thing is that most of the supervisors don’t really even know us to do the work, you know the work of supervision anyway. We know each other in a way they can’t.

The other participants seemed to take offence at this statement as I observed them laugh once informant #5 made the comment. Informant #2 stated,

The meaning for me is the same like let's get this straight. You guys want me to put the consumer first, like always, finish my paperwork within 24 hours, do all these other things and you can't put me on your list?

Some of the group seemed to concur with the statement. Informant #3 explained, "I think for me the meaning is that my emotional well-being is really not that important and my professional well-being is only as important as long as it doesn't negatively impact my work." Informants #1, #2, and #6 shook their heads to confirm that statement while informant #4 attempted to remain neutral. Informant #6 agreed with the statement but also clearly explained that she felt it was the responsibility of the team, not just a supervisor, to help with some of those skills that may be lacking. The group continued to make sense of the two themes, and informant #5 shared, "I really still think that if two people are drowning and one is able to keep themselves afloat, for lack of a better analogy wouldn't we save the drowning people? I mean that is crisis 101." Most group members discussed that everyone needed supervision regardless of skill level, and that supervision should actually occur more for people who do have a strong skill set in order to enhance skill sets. One participant compared it to the teacher who pays the most attention to the kid that is struggling while the other students rarely have one-on-one time unless there is an issue. The group had a strong reaction to his comment because they felt that the analogy was harsh and that supervision should not just focus on people who are not doing well. Informant #2 requested that they move on to another theme, and the group's silence provided tacit agreement.

The next theme discussed was *supervision for self-care*. Informant #5 introduced the theme and discussed how team building and self-care would be helpful for staff.

Informant #2 said,

For me, self-care is first on that list. I mean at some point without that none of the other stuff matters. Like, heard you saw someone die today. Must have been rough. I mean at our place sometimes there is debriefing but it's with a stranger, not your supervisor which is really, I don't know, awkward.

This seemed to resonate with the group as they all shared comments of agreement that self-care is not happening and is necessary. Informant #3 shared,

I need to know that self-care is a priority in my eyes and my supervisors. Like if you want me to keep running and doing my job, you have to refuel me in some way. Some days I feel like I am running on empty.

Informant #5 agreed as well and then moved the group to the next topic.

Another theme addressed was *evaluation in supervision*. Although the group agreed that evaluation was necessary, there was questioning as to how appropriate it was for supervisors to evaluate people that they do not know. Informant #4 expressed, "I think it's unethical to truly evaluate someone who you haven't met with or monitored at all. Like, not ok. I mean that is me judging a consumer based on their diagnosis without getting to know the whole person first." All the participants appeared to agree. Informant #2 questioned the group, "Do you think your supervisor even knows you?" All the participants with the exception of informant #5 commented that the supervisor does not know them or their work. The participants seemed to make sense of this in the respect



that if the supervisors do not have time for supervision then they should not make time for unfair evaluation. The participants talked about the significance of evaluation and that the supervisor is ultimately responsible for their evaluations when it comes to their work and attitude. The participants seemed to make sense of this theme deeming it “unfair” because the supervisors do not actually take the time to get to know the staff and the work being done, so they have no foundation to evaluate the clinicians. The process made the participants lack trust in the supervisors and in their agencies’ ethics.

The final theme addressed by the group was *supervisors not getting supervision*. Informant #5 spoke first commenting on the how the mental health system, and more specifically crisis agencies, are too busy managing other things and tasks to provide one-on-one clinical supervision to the staff. Informant #2 stated, “Everyone is busy that is true, you know maybe they are burned out and don’t want to talk about those cases because they have their own issues.” The group seemed to be in agreement that while everyone is busy it was a scary thought that people are not getting supported in a system that is designed to support so many others. Informant #3 said,

I just, for me, it’s like no one has time for anyone and that doesn’t feel great. We tell people you know taking care of yourself is most important so you can take care of others. How are we not doing that in a mental health system?

The group was nodding their heads along with the comments that were shared, and as the conversation quieted informant #5 informed me that was all they had. I looked to the group to confirm and they agreed.

### **Focus Group Observations**

I observed that the group seemed to interact and agree on the first four themes: *pride and passion for the work*, *value in the work*, *sense of team in crisis intervention*, and *flexibility needed for crisis intervention*. The first four themes all reflect aspects of the work, and the participants seemed to be able to have an open conversation with confidence about the work they do and in the impact they have on others. I observed the participants joking with one another and sharing stories about the first cluster of themes. There was a lot of energy in the room dissecting the first cluster of themes, as it dealt with pride about their work, responsibilities, the variety, and the partnership among clinicians working in crisis. The group had a strong sense of pride in their work and agreed that there was a unique bonding experience that came along with having a team to respond to crisis calls.

The fifth theme, *emotionally and physically exhausting response to crisis calls*, was addressed in each one-on-one interview and yet, as a group, it was the one theme they touched on the least. As a group they spoke vaguely about the theme of emotionally and physically exhausting crisis events, whereas in the individual interviews a lot of time was spent and many specific stories were shared that reflected that emotional and physical exhaustion. It appeared that the group was not necessarily comfortable enough with one another to divulge that level of personal experience. After discussing with so much confidence and enthusiasm the initial themes presented, their energy level dropped when trying to interpret and make meaning of the theme related to an emotional response to a crisis call.

The next theme was *constant crisis mode*, and some of the participants talked about being constantly in crisis, leading to difficulty of disconnecting from work, and the discussion evolved to how they know when they were detached. Some of the participants

verbalized that they rely on their partners to let them know if they seem to be struggling to detach from the work. It seemed hard for the group to admit flaws or anything that might be perceived as weakness in a room full of peers, whereas in the individual interviews participants displayed more vulnerability when sharing some of their emotional stories.

As the group moved into the theme of *countertransference*, the willingness to offer divergent opinions continued, and people began to align with one another. One informant seemed to notice the shift in group dynamics and offered comments that were more neutral and supportive of both sides of the argument. On this theme, the group differed on whose responsibility it was to help identify countertransference. This was another instance where the response was very different in the group than in the semi-structured interviews. In the one-on-one interviews many participants directly addressed their fear that their emotional baggage did “spill” into calls, and there was a concern about how to receive support for that. In the group, the participants were less willing to open themselves up with one another and divulge that fear.

The next themes discussed were specific to supervision, including *supervision in the moment*, *the function and purpose of supervision*, and *supervision for self-care*. One informant challenged the participants in their experience and meaning of supervision. Informant #5 stood out in this section because frequently he seemed to provide a defense or explanation for why supervision may not be happening or what supervision could look like in crisis. Other informants appeared to physically and verbally react to his defense of supervisors and stressed that regardless of how busy supervisors were the clinicians’ needs were not being met. Informant #4 attempted to be a peacemaker for the group by

verbalizing his understanding of both sides of the issue.

During the discussion on these supervision themes, and specifically what the lack of supervision meant to each participant, informant #2 took a risk sharing his thoughts and feelings on how the lack of supervision and the quality of the supervision he received impacted him. He talked openly about his skills possibly declining due to his lack of receiving consistent supervision. It was the first time in the group that a participant seemed to display vulnerability and personal concern. All of the members in the group, save one, supported him and agreed with him that his fear of not growing because of inadequate supervision was a legitimate concern they shared.

Finally the group addressed the purpose of supervision, as well as their expectations for them in supervision. There seemed to be more agreement on this topic, as they agreed that the supervisory functions of case consultations, team-building, and professional development should be addressed on a regular basis. The group also agreed that supervisors should be required to address the self-care of clinicians in the field of crisis and that supervisors have an ethical responsibility to monitor the fitness of the clinicians under their supervision. The group agreed that well-being was crucial to their job and that it would be helpful to address it and work on it with supervisors who were removed from the actual crisis calls. Informant #5 still seemed to provide a justification for the lack of attention to self-care in supervision, sharing that supervisors were doing the best they could to support staff. As the conversation faded the group terminated the discussion, and I offered to stay back and meet with any individuals who needed anything additional from me. No one took me up on the offer, but most did stop to thank me for paying attention to something that they felt gets overlooked so often as “just the way it is.”

## Focus Group Themes

Similar to the individual interviews, the focus group evoked different emotions, and new themes emerged. The group worked together to make sense of the themes from the individual interviews and discussed their meaning for each theme. Commonalties existed between the themes from the individual interviews and the focus group. The same process of identifying statements and formulating meanings was conducted to analyze the data from the group. After the meanings were formulated they were labeled into theme clusters, and eventually new emergent themes were created from the clusters. The final themes can be seen below in Table 2 (as well as Appendix M).

**Table 2**

### Meanings and Emergent Themes, Focus Group

Formulated Meanings	Cluster Themes	Emergent Themes
Demonstrate confidence and value.	Clinicians' perceptions of themselves.	Clinician confidence.
Group has strong understanding and appreciation of teamwork.	Group's perception of team is that it is effective and helpful.	The necessity of teamwork in crisis.
	Clinicians' management of work.	Clinicians' self-care process in crisis.

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Certain	Clinicians'	Crisis culture.
characteristics	perception of	
needed to be a crisis	common and	
clinician,	necessary traits to	
similarities of crisis	do effective work.	
culture.		
Clinicians'	Clinicians'	Experience of
understanding of	perception of reason	clinical supervision
supervision and its	and purpose of	in crisis.
components.	supervision.	

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### **Clinician Confidence**

The focus group elicited responses from the participants on their own individual meaning and experience with the identified themes. Although the responses varied, the confidence they exuded in their purpose as crisis clinicians was consistent and clear throughout our time together. One informant shared, "People at my agency always refer to us as the 'cocky group' and I take that as a compliment because we are confident in what we do and we are good at it." The other members of the group agreed with his sentiments. In regards to their skill, participants seemed to feel confidence in the skills required to perform the necessary duties of a crisis clinician. One participant expressed, "I think that our work is really important, and I think my skills that I naturally have fit with the field." The group demonstrated confidence throughout all the themes discussed, and it was evident that the confidence was shared across the individuals, regardless of the agency

with which they were associated.

### **The Necessity of Teamwork in Crisis**

The focus group became a team in and of itself in discussing the emerging themes presented to them. They worked together discussing shared meaning and experience in respect to each theme and discovered many similarities between them. One participant identified, “We kind of already formed a team here!” The group discussed several times throughout their time together how important the concept of “team” was to them in crisis work, whether on the actual call or to process after the call. One member shared, “I mean they keep me sane. They help me make sure I’m like on the right track. They know my work and my mood.” The theme of teamwork continually presented throughout the group, and it appeared that the informants relied on their team as a form of support in lieu of supervision. One participant stated, “I think that is why we are in teams, since supervision isn’t happening at least we have our partners.” The theme generated conversation, and there seemed to be some consensual understanding of the significance of teamwork in crisis intervention.

### **Crisis Clinicians’ Process of Self-Care in Crisis**

There was acknowledgment throughout the group about the challenges in crisis work and the impact the work had on the members. The group processed the need for self-care in order to continue functioning at a high level in their work. Self-care or self-preservation held significance for the participants in managing the work and the intensity of some of the crisis calls they experienced. The group conversed about how difficult some calls are and the need to work through those emotions. Although in the individual interviews the informants shared many stories, in the group they remained reserved when it came to

details. The group did reflect on the emotions surrounding challenging cases. One informant shared, “If someone asked me I could probably describe in detail several crisis calls that are still with me.” The group agreed that intense calls seemed to linger and make it hard for them to transition to the next situation with tending to some self-care and processing the complex emotions that can emerge from those events. One informant expressed,

I think I have a good amount of self-awareness. I know I have disconnected when I my muscles can breathe and I am thinking about something other than safety or death or danger. I have those moments and I try to tune into them for my own sanity.

The group identified the need to disconnect in order to recover from crisis calls in addition to utilizing their team as a support to process events. One participant shared,

Oh yeah, I mean I can recall most calls, but definitely ones that were emotionally trying I can tell you everything. That’s the thing with the teamwork that is so important. I need some space and someone to talk to about that so it doesn’t hurt another call, that is like a big fear I have.

The theme of teamwork seemed to coincide with self-care as the group identified it as one of the ways they were able to get some relief from the challenging workload they faced. The group discussed the importance of taking care of themselves, but ultimately noted that the best way to help themselves would be through consistent supervision to work through some of their emotions as well the outcome of the crisis calls they tended to on their shift. Their well-being was a thread woven throughout the focus group.

### **Crisis Culture**



The theme of crisis intervention having a specific culture of people was apparent throughout the interviews, but made clear in the focus group as they identified specific traits that separated them from other professionals in the counseling profession. One informant shared, “You have to be a chameleon and change with the setting.” The group seemed to agree with the statement commenting about the need for flexibility in the crisis environment. Another participant shared, “I mean if you are a concrete thinker and that is the environment you thrive in, you can’t, I mean you like can’t do this work.” The group discussed that the culture had to demonstrate flexibility and see more grey than black and white to survive. Another informant explained, “I think the thick skin is necessary, it would also be nice every once in a while to be human.” The statement indicated that crisis clinicians had some superhuman traits of inner strength in order to do the work they do. The group shared similar thoughts on what it takes to be in crisis work. The unique culture they described about needing “thick skin” or being a “chameleon” seemed to imply that clinicians were isolated and had to manage emotions and challenges on their own, without supervision, in order to thrive in the crisis environment.

### **Experience of Clinical Supervision**

Throughout the focus group, support was a focal point for the members. Various ways of support emerged throughout the discussion and seemed to lead back to the need for clinical supervision. The participants exuded confidence when describing their skills and purpose in the field, but appeared less enthusiastic when it came to discussing supervision. Some of the members expressed frustration over the lack of supervision and interpreted the limited support to mean that they were isolated in doing their job. One participant stated,

The meaning for me is the same like let's get this straight. You guys want me to put the consumer first, like always, finish my paperwork within 24 hours, do all these other things and you can't put me on your list? Like why should I do this for you? I mean, like I do it. I do it because I want to and because I like this job and this field, but that is shady.

The members talked about their job requiring them to put others first and always attend to the needs of others but at the end of the day the clinicians' needs did not seem to ever be a priority. The group demonstrated hostility about the agency they were in not making time to provide support for the staff. One participant expressed, "I don't know how I feel about this. It's kind of scary because of the work we do. Like who is looking out for us and who is looking out for the supervisor? I feel kind of alone thinking about this."

The group also identified that one purpose of supervision is to evaluate the clinician's skills and development. This created some tension for a member who stated, "I think it's unethical to truly evaluate someone who you haven't met with or monitored at all. Like, not ok. I mean that is me judging a consumer based on their diagnosis without getting to know the whole person first." The group agreed with the statement, but provided a suggestion that teams were put in place so that the supervisors were not the only ones responsible for providing that support or debriefing necessary after crisis calls. One informant shared, "Well, yeah, but the thing is that is why we have partners. To help us see what we can't and then if there is a problem it can be addressed in supervision." Aside from that informant the rest of the group wrestled with the idea that the partners had such an important responsibility that should be handled by a supervisor. The group felt that the partners were at risk for the same vulnerability due to their exposure on crisis

calls and that a supervisor, a third party, needed to be the one to support and advise staff on professional and personal development.

The group dedicated time to conversing about how supervision could support them and steered the conversation towards self-care. One participant stated,

I need to know that self-care is a priority in my eyes and my supervisors.

Like if you want me to keep running and doing my job you have to refuel me in some way. Some days I feel like I am running on empty.

The group identified that supervision was a way to refill their clinical and personal tanks so that they could keep going and do the work. The purpose and meaning of supervision seemed important to the group as it came up throughout each theme. The group differed on who was responsible for making sure supervision occurred, but all were in agreement that it was necessary to foster and enhance clinicians' personal and professional well-being in the field of crisis intervention.

### **Summary**

This chapter summarized informant interviews and discussed the statements that were identified and placed into categories according to Van Manen's existentials and formulated meaning. This chapter illuminated the process of taking the formulated meanings by the researcher, creating clusters, and then identifying emergent themes from the individual data. This chapter discussed the process and observations of the focus group and group members' understanding of the themes identified by the researcher in this study as it relates to clinical supervision in crisis intervention. This chapter revealed the data and the process of data collection and analysis.

## Chapter V

*“There are two possible outcomes: if the result confirms the hypothesis, then you’ve made a measurement. If the result is contrary to the hypothesis, then you’ve made a discovery.”*

—Enrico Fermi

Engaging in a qualitative study provides an opportunity to learn about phenomena as they are lived. In addition, it invites the researcher to share a journey with the participants as they make sense of that lived experience. As the researcher, this process gave me a perspective of the phenomenon of clinical supervision and its impact on crisis clinicians in their everyday work. This perspective allowed me to observe the participants make sense of their experience as they were sharing it. I had previous experience as a crisis clinician, receiving supervision, and as a supervisor, but these participants invited me into their world to see a different side of crisis intervention and supervision that I had not known. My experience was as enlightening as it was challenging. I was privy to spending time with participants who opened themselves up to the process and shared personal stories and thoughts about their day-to-day experiences, including many experiences that were familiar to me. They shared stories of loss and tragedy that were still unresolved from their work and the lack of support they felt from their supervisors. It was challenging for me to hear their lived experiences, because at times it was surprising and at other times disheartening. Ultimately, this experience was an opportunity for me to learn more about the lived experiences of working in crisis situations, and it also provided an opportunity for the participants to share their stories and connect with one another about the meaning of their experiences. Using a qualitative design enabled me to

learn from the participant perspective. By not having specific a priori questions, but rather only using guiding questions, I invited the participants to elaborate and share whatever they felt comfortable with disclosing from their unique perceptions.

This chapter organizes the themes from the participant interviews using a hermeneutic phenomenological approach to examine the lived experience of clinical supervision for crisis clinicians. Specifically, this chapter illuminates the themes in relationship to the original research questions of this study. Additionally, this chapter describes and discusses the emergent themes of this study through the lens of social constructivism and constructivist self-development theory (CSDT). Finally, this chapter addresses the limitations of this study and the resulting implications for practice and further research.

### **The Process of Interpreting Results**

Hermeneutic phenomenology attempts to unveil the world through the experience of the participants as they describe their life-world stories, and this description is an interpretive process (Heidegger, 1977; Van Manen, 1997). Using this method and the guided steps of hermeneutic phenomenological approach, I extracted detail in the words used by the participants and formulated meaning from the data. After formulating meanings for the statements, cluster themes were identified to help categorize all the rich detail and produce emergent themes from both the individual interviews and the focus group.

Hermeneutic methodology identifies four phases of the data analysis process in this type of research: (1) turning to a phenomenon, (2) investigating experience, (3) reflecting on themes, and (4) describing the phenomenon (Van Manen, 1991, 1997).

## **Turning to a Phenomenon**

The experience of clinical supervision and how, or if, it supports clinicians in crisis work was the focus of the study. First, I reviewed the previous literature to collect and explore information and previous studies regarding clinical supervision and its purpose within the field. Turning to the phenomenon of clinical supervision and immersing myself in the literature was the first step in this study. Van Manen (1991, 1997) encouraged phenomenological researchers to turn to a phenomenon that seriously interests us and commits us to the world. As the researcher and the primary instrument in the study, I have a personal investment in the phenomenon as it relates to crisis work. My interest and investment in the phenomenon enabled me to open myself to the various aspects of clinical supervision prior to exploring the lived experience as reported by the participants. According to ACES (2011), when considering best practices in supervision, “The supervisor operates with an awareness that the supervisory relationship is key to the effectiveness of supervision as well as the growth and development of the supervisee.” The literature illustrates the significance of supervision as well as the supervisory relationship in relationship to fostering growth and well-being for clinicians. The literature suggests that organizations and agencies have a moral obligation to consider the welfare of crisis workers as first responders (Alexander & Klein, 2003). The exposure to the phenomenon led to the development of the research questions that drove this study:

1. How do crisis clinicians experience supervision in crisis work?
2. How do clinicians describe their relationship with their supervisor?
3. What does supervision mean to clinicians in crisis work?
4. What is the focus of supervision in crisis work?

5. In what context is supervision received?
6. How do crisis clinicians describe the purpose of supervision?

Similar to turning to the phenomenon of supervision, it was equally important for me to explore the other major aspect of the phenomenon, the crisis clinician. My own experience provided a foundation of knowledge and understanding of crisis work, but I reviewed the literature to ensure that I explored other reported perspectives on this element of this phenomenon.

The literature presents crisis intervention as a unique subset of the counseling field having the unique characteristic of its immediate response and brief contact with consumers. Crisis clinicians seem to be a population all on their own, and it was necessary for me to search the extant data and literature on this unique population prior to engaging in interviews. According to Roberts (1995), a crisis clinician's task is to assess psychological and situational crisis in terms of danger and opportunity. Clinicians are exposed for long periods of time to critical events and have to maintain composure and professionalism. The aftereffects can either positively or negatively affect clinicians (Figley, 2002; Hanafi, 2008; Naturale, 2007; Roberts, 2005). The clinicians are trained to do ongoing and rapid assessments, which leaves little time for processing on a call. Grodzki (2006) discussed that in war soldiers are triaged and prioritized for treatment and that people who have a better chance of surviving are provided aggressive forms of care while others wait. The example of triaging people who need the most immediate care is reflective of what is done in crisis work and clinical supervision. Grodzki's example of triage and treatment is something that seems to be overlooked in clinical supervision in crisis work. Clinicians are waiting for supervision and support, and no one is tending to

their needs. There has been little research on the common characteristics of crisis clinicians, but an abundant amount of literature is available on crisis clinicians as first responders and burnout for therapists who work with challenging populations. Therapists or counselors who work with trauma victims are most commonly identified as people who struggle with burnout due to the intensity of the work (Figley, 1995; McCann & Pearlman, 1990). Crisis clinicians fall under this umbrella because much of their work is with trauma victims and perpetrators. The literature identifies areas where trauma counselors experience a shift in cognitive or emotional states, which can impact their perception and emotional safety (Pearlman, 1999). The literature regarding potential impacts on clinicians working with challenging populations supports the need for further understanding the lived experience for how they receive support in the field.

### **Investigating the Experience**

The phase of investigating the experience begins with the researcher identifying his or her experience. Hermeneutic phenomenological research uses the researcher as the instrument to explore the lived experience of the participants, as they perceive the phenomenon of interest. Therefore, it was essential that I, as the researcher, took time to explore my own thoughts, connections, and experiences in order to be aware of them and their potential interaction with the study. Using the bracketing methods of reflexive journaling and writing memos allowed me to investigate my experience as well as the reported experiences of the participants in this study. I used reflexive journaling throughout the process in addition to memos to ensure that I was capturing my own perceptions so as not to confuse them with the interview data.

The next step in investigating the experience is to engage the participants in



activities to elicit their understanding of the phenomenon. The interviews and the focus group discussion provided unique opportunities to interact with the participants and hear their personal narratives about each informant's lived experience of the phenomenon under investigation. The lived experiences provided real examples of the phenomenon and how the people working in crisis on a daily basis perceived it. I attempted to immerse myself in the interviews as well as the focus group in order to increase the probability that as much of the rich detail as possible was extracted in order to increase the trustworthiness of the participants' derived meaning.

### **Reflecting on Themes**

The third phase in the hermeneutic phenomenological approach is reflecting on and interpreting themes that emerge from interviews and focus groups. I continued using my bracketing methods throughout this process when reflecting on themes to ensure that I was focused on the experience of the participants. The bracketing methods enabled me to immerse myself in the data and identify certain experiences that I felt connected with, while ensuring that the themes that were reflected came directly from the participants' lived experience. The themes that emerged from the interviews were collected and categorized. The themes were then presented to the participants in the focus group to further validate and clarify the findings of the researcher. This process of group reflection gave the informants the opportunity to make sense of the themes that emerged from their individual interviews.

Reflecting themes using a hermeneutic phenomenological method means that the data are not examined to answer a question, but rather to clarify and deepen the understanding of the components of the phenomenon through the lived experience

(Heidegger, 1977). I used a recursive process in my reflection on the emerging themes: I wrote notes on potential themes and went back to the data several times to ensure that I explored every aspect of the data. I listened to tapes, wrote down phrases that continually presented themselves, and labeled them with Van Manen's lived existentials in relation to the phenomenon. I compiled the themes from my data collection, with a few clarifying phrases below each theme, for distribution at the focus group discussion (Appendix K). Similarly, after the focus group, I went through the same process of identifying statements, formulating meanings, labeling cluster themes, and producing emergent themes (Appendix M).

### **Describing the Phenomenon**

There is a difference between understanding a phenomenon intellectually and understanding it from the language of someone's lived experience inside that phenomenon, and that is where hermeneutics is unique (Van Manen, 1991).

Hermeneutics provides insight from people who actively do the work rather than standing outside and trying to theoretically grasp a concept by observing it. I was drawn to hermeneutic phenomenology for several reasons, one of them being that it is concerned with describing a phenomenon using human experience as it is lived and illuminating details that may be taken for granted. This step in the approach is not concerned with a theoretical description of the phenomenon. Rather, it is focused on using a rich and thick description of the lived experience to enhance our understanding of the phenomenon of interest. Van Manen (1990) stated, "the facts of lived experiences are always already meaningful (hermeneutically) experienced" (p. 18). The interaction with the participants to uncover their lived experience was an interpretative process to learn more about the

experience of the phenomenon of clinical supervision through the perspective of crisis clinicians. Although one interpretation does not represent all possible explanations, it does provide firsthand experience, through participant stories, of the essence of the experience with the phenomenon.

### **Discussion of Findings**

ACES (2011) has identified best practices for clinical supervision, including the parameters and purpose of supervision. After spending time with participants in the interviews and the focus group, it was clear that supervision is not being experienced in the way it was designed according to best practices in crisis settings. Many of the clinicians that I interviewed during this study discussed their uncertainty of what supervision should look like, but were able to identify how supervision could and should fulfill and support their needs as a professional in the mental health field.

The participants' experiences with clinical supervision were revealed in the narratives generated in the interviews and focus group. The resulting data were analyzed to yield themes in relation to the original research questions proposed during the process of turning toward the phenomenon at the beginning of this study.

The findings from the interviews and the focus group coincided with the questions identified at the beginning of the study. Each questions was answered in rich detail from the participants to help better understand the phenomenon of clinical supervision in crisis work.

#### ***How do crisis clinicians experience supervision in crisis work?***

The purpose of this study was to explore crisis clinicians' experience of supervision. In most of the interviews clinicians offered stories of their perception of supervision without

being prompted. Clinical supervision was a thread that was laced through the lived experience of each participant's description of his or her work. Although informants shared their own unique stories, there were many similarities in their experiences of clinical supervision in crisis work.

Several of the participants shared their experience regarding limited or no supervision, but quickly explained that it was not happening due to the design of the system. One informant shared, "Supervision is a requirement, but like I am not sure I can really talk about the experience because it's confusing. I mean there is administrative stuff, but supervision is rare and it changes depending on the day." Their perceptions of supervision seemed consistent, indicating that supervision had not been a supportive and consistent process. Another informant shared, "My experience of supervision is that I get it in some form, I touch base with someone but I am never satisfied." Participants shared that in addition to supervision being infrequent, it also lacked the support that clinicians were seeking in terms of skills development and self-care. The clinicians spoke about wanting more from their experience and shared personal stories and how supervision could have been helpful. One participant shared that his supervisor's inability to be there for him after an emotionally challenging call was a lost opportunity and damaged any potential supervisory relationship from developing. The informants felt strongly that supervision was necessary and that their current experience did not meet professional standards or the individual needs of the staff.

All participants shared the experience of clinical supervision that lacked structure and timeliness. The informants also shed some light on why the experience might have been so challenging. An informant stated, "The supervisors are busy and aren't getting

supervision either.” Informants offered potential reasons to explain why supervision may not have been a good experience, but still identified that supervision was not typically available.

There were some differences among the informants when it came to how they qualified their reaction to this experience. Some informants displayed anger and frustration, whereas others described the lack of supervision as a testament to their abilities and skills because they did not require it. Informants who had worked longer in the field appeared more understanding of the lack of supervision. Overall, clinicians working in crisis intervention experienced clinical supervision as limited and did not feel that it fulfilled their expectation or met their needs.

***How do clinicians describe their relationship with their supervisor?***

Relationships were discussed many times in the interviews and the focus group. The clinicians talked about relationships in regards to their consumers, their teammates, and their supervisors and how those relationships impacted their personal and professional stability. The clinicians identified that relationships were important to them in this work and that was what they valued greatly in their partners. The relationship appeared to be lacking when it came to supervision. The informants were unique and expressed varied opinions, but they all were in agreement that there were poor relationships or no relationships at all between them and their supervisors. One informant commented on the lack of relationship with her supervisor, stating,

Supervision could be so much to so many of us, or at least to me, but I barely even know him. I don’t know even know much about his professional history and he definitely doesn’t know about mine. How do you sit with someone who barely

knows what you are even about and give them feedback or support?

Her identification of this lack of professional relationship was noticed and increased some of the tension that occurred when she would actually have to face her supervisor. Her rhetorical question addressed a major issue in the supervision process. Without prior knowledge or understanding of the other person, the ability to form a collaborative supervisory relationship can be difficult. The failure to foster relationships between clinicians and supervisors may also contribute to supervisors avoiding supervision with the staff. Another informant shared,

I would like for my supervisor to know me; I mean that would be the first step. For them to know us the way we know each other. If there was a relationship it might be easier, you know? One hour, uninterrupted by crisis, to sit and be heard.

Participants reported a strong sense of bonding and teamwork among clinicians who work responding to crises and how it contrasted with the inadequacies in their relationships with their supervisors. The clinicians, knowing and feeling what it is like to have a supportive relationship with a peer, were made more aware that they did not have that type of relationship with their supervisor. One participant talked about whom they turn to for support, “I trust my partners; we’re pretty close.” Clinicians relied more on each other than their supervisor in most circumstances.

Comments made throughout the interviews identified that a first step to getting effective supervision would be a relationship between the clinician and supervisor. In the focus group this theme was supported with statements such as, “The thing is that most of the supervisors don’t really even know us to do the work, you know the work of

supervision anyway. We know each other in a way they can't." The limited relationship between clinicians and supervisors created difficulty in achieving the support they were seeking for personal and professional development in crisis work.

***What does supervision mean to clinicians in crisis work?***

Bernard and Goodyear (1998) suggested that clinical supervisors did not need to be good therapists because different skill sets were required for supervision than therapy. Bernard and Goodyear (2004) also recognized that there was an aspect of counseling in supervision, as the focus is on how the supervisee impacts the client as well as the supervisee's personal and professional well-being. It became clear after spending time with the participants in this study that there seemed to be a therapeutic component that many of them were searching for in supervision. The participants recognized that supervision meant evaluation and professional skill development, but mostly it appeared that the participants were seeking support and guidance to manage their own emotional responses toward their work. They were seeking support for their personal well-being. One informant shared his meaning of supervision, stating, "I want supervision to at least acknowledge that this job can take its toll on people. Supervision to me at least would be my time." The participants made sense of the meaning of supervision as indicated by what they were not receiving and felt was necessary in order to help them do their job. Informants identified that supervision would mean additional support for them as well as the consumers they served.

The theme of supervision including personal support carried through the interviews and was confirmed during the focus group. Participants clearly stated that the meaning of supervision for them was for their supervisors to support their personal and

professional needs. The informants shared stories of how their work has impacted them and talked about how supervision would have been helpful to address those moments when they felt their emotions were difficult to manage. In many ways they were doing just that with me during the interviews. They would talk about consumers and clients and how certain situations made them feel and then discuss how supervision would have meant so much to them. I felt as though they were using the interviews with me therapeutically, as if to demonstrate how supervision could address their needs and to validate their recognition of counseling as a function of supervision.

***What is the focus of supervision in crisis work?***

Similar to the meaning of supervision, the focus of supervision shared similar patterns for the participants. Bernard and Goodyear (1998) identified that, among other things, clinical supervision should focus on building counselor skills and competencies. This study explored the experience of crisis clinicians and how their understanding of the focus of clinical supervision differed from what textbooks described as the intended focus of clinical supervision. One informant explained, “Supervision is for when you like, get in trouble or something. That is when I see my supervisor the most. Otherwise, it’s hard to say.” The focus of supervision varied among participants, but overall seemed to carry a theme all on its own that the focus of supervision was more administrative than clinical. Another informant explained,

You know when things go bad on a call that is when I get supervision the most. Not bad like death, because that happens on a lot of the calls, but bad in terms of I missed something then a supervisor really wants to be a supervisor.



The participant elaborated on supervision being an intervention focused on correcting things that went wrong, which was another theme that coincided with administrative supervision.

Another theme threaded throughout the interviews regarding the focus of supervision was the idea that the actual focus was not up to the staff, but rather the supervisor's agenda. The clinicians discussed the evaluative component of supervision as a focus, and this created discord among the group because they perceived the evaluations unjust due to the supervisors not spending adequate time with them in their work. The focus of supervision being experienced as administrative and never about the staff themselves created more distance between the staff and the supervisors, ultimately resulting in minimal supervision and support in crisis work.

***In what context is supervision received?***

When people think of supervision they may visualize an office or at the very least an enclosed place where two or more people are interacting with one another. The context of clinical supervision varies, and it is clearly unique in the crisis environment. All of the informants in this study addressed the context of supervision as a hurried moment between them and their supervisor. One informant identified that he sat with the supervisor in the office when it was time for an employee review, but other than that the participants discussed that supervision happened much like crisis work—in the moment and wherever they found themselves. One informant noted, “I would first make it mandatory to actually sit down and meet. Sit in like, an office, not the hallway or the parking lot where we happen to run into one another.” The participant illustrated what seemed to be shared among all participants, that supervision is a check-in and can be

fleeting. When describing the experience of clinical supervision the informants used words such as “rare,” “awkward,” or “quick,” indicating that there was a lack of quality or utility in the connection between the clinicians and the supervisors.

The lack of stable context for supervision indicates that the supervisor does not have the time or luxury to sit and provide actual supervision to staff. The context was significant to the participants, because it was described in ways where whatever little supervision was received was rushed. One informant commented, “I remember coming back from the event after my relief came in and in the parking lot my supervisor saying to me, ‘Go home and get some rest. We have a lot of work to do tomorrow.’” The examples of when the participants felt they were receiving supervision or at least receiving the attention of their supervisor almost always occurred randomly and in settings that provided no privacy or space for the staff to share their thoughts and emotions. In counseling, there is an emphasis on client confidentiality; in the case of supervision, confidentiality is difficult to protect when it is happening in a hallway. One informant shared, “The supervisor grabs you in the hall or something and wants to do this quickie supervision so you feel kind of cornered and you can’t think of the million things you know you want help with in that moment.” The supervision context is reflective of the context that the clinicians are used to on crisis calls—rushed and only focused on certain items to progress the call and solve problems quickly, and hopefully effectively.

### ***How do crisis clinicians describe the purpose of supervision?***

At the start of this study one of the main goals was to understand how and if clinical supervision was a support to crisis clinicians. The participants wrestled with how supervision had supported them as well as its purpose in the field of crisis. One

participant described, “I think supervision should have professional development and like personal, not counseling or anything but I guess self-care and management. I mean without someone helping with my skills they won’t grow.” The participant identified professional development and self-care as two important aspects of supervision, which aligns with Bernard and Goodyear’s (2005) understanding of clinical supervision including professional development and promotion of personal well-being. Another participant explained, “Supervision should be consistent and structured, not haphazard.” In ACES (2011) best practices, both of these issues brought up by the participant of the importance of a supervisory relationship as well as consistent and regular supervision are addressed. ACES describes the need for the supervisor and the supervisee to agree on the time, place, and duration of supervision as well as a discussion of the collaborative working relationship.

One participant described the phenomenon as, “The purpose is to help us help the consumers, the clients, to make sure we aren’t letting our stuff get in the way.” Another vital aspect of the supervision process, according to ACES, is for the supervisor to provide feedback to the supervisee, and many of the participants identified this aspect of supervision an important one for them so they can grow and develop while ensuring that the clients’ needs are met. Another participant identified,

I guess ultimately supervision should include team supervision, case reviews, and probably some self-care stuff. I mean we see so many people, so many patients a day that the supervisor has no idea of all the people we come in contact with on a daily basis let alone a weekly one.

The issues addressed by the participant of case reviews speaks to the obligation that

supervisors are technically responsible for all the clients their supervisees work with on a daily basis (Bernard & Goodyear, 2005). Ultimately, describing the phenomenon using the experience and texts of the participants fits the already known definition of clinical supervision in the mental health field. Another informant shared, “I think that supervision would be helpful if I could really discuss cases and my emotions around it. I can let go of things once I have that moment and get some perspective.” The purpose of supervision is clear for this participant, who identified that after having numerous emotionally draining calls she needed to get things off her chest and process the calls. One informant stated,

I want someone to tell me if I am doing something wrong and when I am doing it right. I want to manage stuff. I want supervision to at least acknowledge that this job can take its toll on people. Supervision to me at least would be my time.

Another important theme of the purpose of supervision was skill development. People wanted to know what they were doing well and what was not working, so that they could see improvement. Many of the participants discussed wanting to be not in crisis mode and actually have time that was about them and not everything else throughout the day. Another informant identified, “The purpose is to help us help the consumers, the clients, to make sure we aren’t letting our stuff get in the way.” The theme of potential countertransference emerged throughout the interviews as well as the focus group. People felt that supervision should be able to provide an intervention to help increase self-awareness for clinicians working in this type of field. Many participants shared that the purpose is to discuss cases, develop skills, and make sure people are doing the self-care that is required to sustain in the field.

## **Social Constructivism Themes**

One of the theoretical lenses used to analyze the themes that emerged in this study was social constructivism, particularly its emphasis on social interaction as a means to learn (Crotty, 1998; Vygotsky, 1962). Vygotsky's (1962) contribution of the zone of proximal development (ZPD) demonstrated that, in most cases, people are able to recall information better when working with someone else, not with the other person telling or reminding them, but rather, collaborating and interacting with them. Social constructivism and ZPD can be used to understand the crisis clinicians' experience as it relates to their meaning of teamwork and the need for a supervisory relationship. Throughout the interviews and focus group, the participants identified that they felt most confident and learned the most from interaction with their partners.

Throughout the interviews and the focus group, participants identified their sense of team as the most stable part of the job. All of the informants discussed that their partners and peers on their team were the ones who helped them grow professionally, as well as help them manage difficult emotions. One informant commented, "I have a good team to check in with if I feel like I'm slipping." The informants in the individual interviews and the focus group brought the team issue into focus, discussing how their partners are not only great teachers, but also are the ones who provide immediate support and feedback. One informant shared, "We count on each other for feedback and to keep one another in check because no one else does." The crisis clinicians identified that their partners are in the best place to provide feedback to help them grow because they work alongside one another so they share the experience or similar experiences, and these are the people available to have the most interactions with them. This quality of interaction is

absent in supervision. Social constructivists believe that this type of relevant interaction is necessary to promote growth. Clinical supervision in crisis work does not reflect the philosophy and tenants of ZPD and social constructivism. There is minimal to no interaction between supervisors and supervisees, making it difficult for clinicians to experience a safe place of support where they can enhance their skills and foster personal and professional development.

Social constructivism highlights reflection and exchange as two important and effective ways to promote knowledge acquisition. Clinicians described the process of reflecting on crisis calls that were emotionally challenging and needing exchange with someone else in order to work through those emotions. Clinicians identified that without an exchange with their partner there was concern that countertransference on calls was inevitable. Reflection and exchange appeared to be what the clinicians were seeking in supervision. Clinicians were stating repeatedly in the interviews as well as in the focus group that they wanted time to reflect on calls and emotions and have an exchange with the supervisor so that they could move forward and receive feedback. One informant stated, “I can let go of things once I have that moment and get some perspective.” In many ways the interview process was parallel to what the clinicians were seeking in supervision. They spent time with me reflecting on some challenging moments in their work, and we exchanged thoughts back and forth about that impact and then continued the conversation in the direction of their experience of supervision.

### **Constructivist Self-Development Theory**

In this study, constructivist self-development theory (CSDT) was identified as a relevant theoretical orientation to interpret and understand the findings (Kuhl, 1985; Saakvitne &

Pearlman, 1996). CSDT encourages connections between the counselor and the survivor of trauma so that the survivors can learn and experience the trust of another individual. CSDT stresses the relationship as being integral to success in working with people who have survived major loss through a traumatic event.

Counseling is an intense personal relationship that can evoke strong emotions for both the client and the counselor. In crisis intervention, that personal relationship becomes a lifeline for the consumers and the clinicians. Clinicians rely on their relationship with consumers in order to gain enough rapport to intervene and stabilize a situation. Likewise, in clinical supervision an effective relationship enables the clinician to feel the supervisor's support so that their situation can be stabilized.

One of the outcomes of working as a first responder in crisis work is that things are seen that can trigger strong unfamiliar emotions (Figley, 1995; Peters, 2002). Working with people in vulnerable situations can put clinicians in a position to experience vicarious trauma (VT) or secondary traumatic stress (STS) because of the intensity, frequency, and volume of work (McCann & Pearlman, 1990a). Remen (1996) stated, "The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet." Crisis clinicians witness and work closely with people in vulnerable moments, increasing the likelihood of the clinician experiencing a negative impact. Clinical supervision can help mitigate these negative responses and provide an insulated environment where the clinician can begin to process the complex emotions that could emerge in response to the trauma often present in crisis events.

CSDT offers a perspective that helps to explain the theme of absent or inadequate

supervision. Although not all clinicians would qualify their experience as traumatic, many of the clinicians shared stories that still had significant impact on them years later. One informant said, “I walked home with that on that day. I carried it with me everywhere I went, literally felt it lingering in the pit of stomach. Maybe I still do in some ways.” This powerful experience illustrates how profound it was for this informant, and that there were still unresolved emotions and residual mental and physical symptoms, even though it was not described as a traumatic event. CSDT indicates that an experience this strong would be better resolved with a supervisor or counselor where there is an established relationship so that the supervisee can experience safety and trust to better resolve these feelings, seek wellness, and return to effectively doing their job. Clinicians who are exposed to constant trauma need support in order to sustain their wellness and discharge their responsibilities. Anything that interferes with a helper’s ability to help debilitates them and, in turn, causes problems for the client who is in need.

### **Quality**

In quantitative research, readers seek a measurement of the reliability and validity of the study to know the true significance of the results that are reported. In quantitative research, a control group can be added to make up for some of the threats to internal validity, but in qualitative research the matter of validity comes in different forms. Qualitative research is vastly different from quantitative design, so it is only natural that the criteria for judging the validity of qualitative research differ from those for quantitative research. Lincoln and Guba (1985, 2005) identified four criteria necessary for measuring the quality of qualitative research: credibility, transferability, dependability, and confirmability. *Credibility* refers to the truth of the data, *transferability* refers to the



how applicable the data are to other contexts, *dependability* refers to the consistency of the data, and *confirmability* refers to the neutrality of the data shared (Lincoln & Guba, 1985). The four criteria proposed by Lincoln and Guba address the concerns with the validity of qualitative research and enable one to determine the quality of a particular study.

### **Credibility**

Denzin (2005) and Lincoln and Guba (1985) recommended that qualitative studies should have credibility and that the data should be believable from the perspective of the participants. In qualitative research the participants provide their lived experience, and only the participants can truly verify the validity of that experience. Credibility was enhanced in this study by using prolonged and varied ways of collecting data, extracting meaning, and analyzing the results. The interviews were semi-structured, allowing the participants to share whatever they felt necessary with minimal prompts. Additionally, the focus group participants ran the focus group and interacted with one another to come to terms with the various themes that were presented. Both the interviews and focus group were conducted and transcribed in a confidential manner. After transcription, I developed the themes that emerged from the data. After organizing the themes, I presented them to the focus group and asked for the participants to discuss the truthfulness and meaning of those themes. The participants led the focus group and read the themes so that they could make their own interpretations and clarify meaning.

As the researcher, I minimally participated only to facilitate the flow of conversation. Additionally, to further enhance credibility of this study, I offered the participants a chance read through their own transcriptions and to talk with me

individually after the focus group. In addition, I gave all the participants an opportunity to withdraw and/or delete any information presented. After extensive conversation confirming the themes identified and elaborating further on the meaning of their lived experience, all of the participants declined.

Another method to ensure credibility of the study was reflexivity. As the researcher, I kept a journal and memos throughout the process to record my thoughts and reactions to the participants. The journal enabled me to remain fully aware of my own bias and experience that overlapped the lived experience provided by the participants.

### **Transferability**

Transferability refers to the degree that the results of the study can be generalized. Research reaches the level of transferability when the descriptive data can fit in more than one context. Lincoln and Guba (1985) stressed that this was the responsibility of whoever wanted to transfer the findings of this study to another situation. Transferability should not be an issue if sufficient data are presented to allow for comparison. A thorough description of participant demographics is also necessary to enhance transferability of the data. Throughout this study, the descriptive data were expressed through transcriptions of the conversations in both the one-on-one interviews and the focus group. In addition to these descriptive narratives, this study provided descriptions of the participant demographics, the context of crisis work, and the nature of the supervision experiences described.

### **Dependability**

The most widely used way to increase dependability of the study is a dense description of the methodology and analysis of the data. A complete and thorough description of each

step in data collection, sorting, and analysis using hermeneutic phenomenology and Colaizzi's method of inquiry was provided in order to ensure the dependability of the study. This step-by-step reflection is vital so that another researcher could use the same process and replicate the study. In order to protect the confidentiality of the participants who agreed to be a part of the study, which was crucial to the informants' participation, I made the decision not to involve other researchers as a method of enhancing the study's dependability. In order to increase dependability I used the participants themselves to confirm data.

### **Confirmability**

Another important criterion of qualitative studies that was taken into consideration is that of confirmability. Researchers who engage in qualitative designs do so because they have a connection to the phenomenon of interest. I was no exception to this concept. I spent several years as a crisis clinician, as well as several years as a supervisor of clinicians working in crisis. My own experience drove the curiosity for this study. In order to enhance confirmability in this qualitative study it was necessary that the participants' lived experience was theirs, not mine. To help ensure this, I worked reflexively to examine my thoughts and ideas about the research question at the beginning and throughout the research process and how these affected my research decisions, particularly the selection and wording of questions, my relationship to the respondents, and how the relationship dynamics affected their responses. This was a challenge for me, and I had to constantly work to ensure that I remained aware of my own perceptions, opinions, and experience. I used journaling and memos to make sure the data reflected on the participants (Moustakas, 1990). Triangulation was important to draw data from

different clinicians in different settings in order to ensure confirmability. Another important component of confirmability was checking and rechecking the data using key words and descriptions from the participants to support the themes. Environmental triangulation was used to extract information at different times and settings to determine if the environmental factors influenced the description of the lived experience (Burr, 1998; Patton, 2002).

Overall, the quality of the study was maintained and various methods were used to increase the credibility, transferability, dependability, and confirmability of the results. The quality of the study is valuable so that readers can trust the results as true and accurate as they relate to the lived experience to the phenomenon. Lincoln and Guba (1985) stress that strategies to improve the rigor and enhance the quality of qualitative studies are essential in order to fully address the trustworthiness of the data.

### **Quality of the Study**

The first threat to the quality of the study was that the sample selected for the purpose of gathering rich description of the lived experience might not have been representative of all crises clinicians. The data appeared to be saturated after the sixth interview, but there are a myriad of crisis scenarios, and data might be missing from crisis clinicians who had uniquely different types of crises experiences not represented by the participants in this study. The six clinicians in this study shared unique perspectives that provided data from which the themes emerged; however, their unique experiences might not have been representative of all clinicians working in crisis. Using Colaizzi's method of inquiry was a way to ensure data saturation as I, as the researcher, took identified themes back to the focus group for validation and clarification.

Thus, one limitation to this study, and many qualitative studies, is that the sample available requires that any generalization of results to a broader group of crisis clinicians must be done with caution. For example, it is risky to assume that the way these participants feel is descriptive of the way all other clinicians working in crisis feel regarding their experience in clinical supervision. In order to enhance this study's quality and remain mindful of this limitation, I attempted to gather clinicians with varying cultural backgrounds, years of experience, age, and gender in order to capture different representations of the population.

Another important threat to the study related to sampling was the impact that time might have on the data. Ideally, data collection in this study should extend longitudinally to see how clinicians' perceptions change over time and how new experiences impact their perceptions of clinical supervision. One of the ways I attempted to mitigate the effect of this limitation was to recruit a heterogeneous group of participants who had different demographic characteristics and different types of crisis experiences. In addition to participant recruitment, the focus group was scheduled after the semi-structured interviews, providing an opportunity for additional experiences to occur. Also, I emphasized my willingness to be available for participants in case there was more information that they wanted to share.

This study showcased one side of clinical supervision, from the perspective of the supervisee. This study explored the perception of clinical supervision in crisis work according to the crisis clinicians who receive it. The study did not incorporate the perspective of clinical supervisors.

### **Recommendations for Research**

Research is needed to explore the supervisors' perception of the supervision process. The literature supports the necessity of clinical supervision that has both cognitive and affective engagement in order to support supervisees and help them balance complex emotions that could arise in their work (Lambie & Sias, 2009). There were several moments throughout the interviews and the focus group where participants identified that their lack of supervision was a systemic issue. Future research could explore the supervisors' perspective of clinical supervision in crisis work. One issue of relevance might be an inquiry into how and if supervisors receive support from administrators and how that impacts their abilities to intervene with staff. Supervisors have an ethical responsibility to provide supervisees with continuous feedback, and future research could explore if supervisors are getting feedback from their supervisors (Bernard & Goodyear, 2005).

A second recommendation for future research is the replication of this study with a different sample of crisis clinicians to determine the stability of the emergent themes identified. This might include using a design that collects data over time. A longitudinal study might be useful to understand how the clinician's perspective, as well as the supervisor's perspective, of clinical supervision in crisis might change over time.

Additionally, research might be conducted that directly monitors the variables that were represented in the emergent themes of this study. For example, direct observation and measurement of the skill development and self-care of clinicians working in crisis intervention could be examined to determine the impact of clinical supervision. Future research could focus on using direct observations of clinicians' confidence in their skills

and development as result of clinical supervision. Research could focus on supervisors' ability to build therapeutic alliances in order to support and measure skill development for clinicians. A therapeutic working alliance is a collaborative relationship between supervisor and supervisee that emphasizes mutual responsibility for the work (Bordin, 1983; Falvery, 2002).

Future research should focus on ethical guidelines as a framework to evaluate the current supervisory practice. Standards exist, but little is known about the structure of clinical supervision in practice at the crisis level. Literature has indicated that the absence of a consistent framework for clients in crisis poses a risk for the profession, the first concern being that professionals are not being prepared and supported for the work they are engaging in as clinicians (McAdams & Keener, 2008). Research could help determine interventions that supervisors implement to support counselor development and interview the counselors to identify how they receive support for their skill development.

### **Implications for Practice**

After reviewing the literature it was evident that crisis clinicians are a distinct population and that there was not a sufficient description of how those clinicians receive support through supervision. When I first began this study, it was apparent that there was a lot to learn about this phenomenon in the field, and who better to learn from than the people who do the work on a daily basis. The findings in this study illustrate that clinicians are working long hours in intense situations with minimal to no support. The literature indicates that lack of support coupled with the environment and type of work can lead to burnout, compassion fatigue, vicarious trauma, and other self-care concerns (Figley, 1995; Roberts, 1990). Burnout in clinicians can lead to consumers not getting their needs

met, as well as a plethora of ethical issues that can have lasting negative effects. Research has been done on how to support people who are experiencing burnout in the field, and clinicians have identified active coping strategies, such as seeking support, making plans of action, and employing humor (Arvay, 2001).

This study opened the door to provide an initial view to look inside what is actually happening in the field of crisis intervention, but there is still a need to explore this phenomenon in more detail so as to better understand the practice and effects of supervision for crisis clinicians. This study illustrated a lack of disconnect between supervisors and supervisees, at least from the clinicians' perspective. Supervisors play a critical role in the development and support of clinicians, and it is important to establish a supervisor relationship that can foster that growth and development (Bernard & Goodyear, 2004; Holloway, 1995). Supervisors need to work on developing and maintaining a relationship with clinicians so that open communication can be established and consistent supervision can occur (Holloway, 1995).

Supervision is fundamental in providing support and facilitating personal and professional growth (Lambie, 2009). Knowing that this is vital intervention to support clinicians who are doing frontline work, it is imperative that supervisors are researching and reinventing new ways to connect with staff and helping them process complex emotions associated with crisis work. In this study, clinicians identified that supervisors were not getting support, which was impacting their inability to provide support for staff. Getz (1999) recommended formal peer supervision to ensure constant feedback. The supervisors can then provide supervision to the peers, which would help to ensure that clinicians are getting the feedback that is needed and the supervisors would have fewer



individuals to supervise.

The findings from this study demonstrate the importance of support in clinical work, specifically in crisis intervention. Some literature identifies live supervision as a possibility to solve some of the issue of supervisors not having enough time to spend with supervisees. The literature supports that in crisis response, regardless of the business of the supervisors, it is essential for counselors to feel not only supported, but also prepared to manage crisis responses (McAdams, 2008). Education, support, and rehearsal have been identified as three interventions that can reduce the risk of negative outcomes on calls, which increases self-efficacy and confidence of clinicians (McAdams & Keener, 2008). Those three interventions can be done in supervision to promote clinician personal and professional well-being.

### **Conclusions**

It was challenging for me as a clinician and as a supervisor to know that some of the emotional wounds we experience with consumers are still very open for the frontline staff. The open wounds make us more susceptible to inflicting countertransference and possibly causing more harm to clients than intended. In the ethical codes for counseling and counseling-related professions, we preach “do no harm.” One of the findings of this study illustrated that there are times we are doing harm, unintentionally, because crisis clinicians do not seek or receive adequate support through clinical supervision. Crisis clinicians identified that supervision is needed to provide support. The literature suggests that there is potential risk to clinicians’ personal and professional development because there may be feelings of guilt, resentment, anger, or sadness from crisis events that they were involved with as professionals (McAdams & Keener, 2008).

Ethical codes and best practice guidelines in counseling also indicate that clinical supervision is a requirement for professional practice, but this study demonstrated that in some crisis settings it is rarely occurring. The participants in this study identified that not only was their supervision unsatisfactory, but many struggled to recall the last time they actually sat down with a supervisor. This causes great concern not only for the clinicians, but the consumers who are expecting well-trained, educated, and prepared staff to help manage crisis events. This study provided evidence that there is a need for this type of support to help clinicians with their personal and professional well-being. The themes that emerged from this study validate the intensity of the work and the stress that clinicians carry with them. The literature has addressed that stress and its outcomes are a significant problem in the mental health field (Edwards & Burnard, 2003; Bernard & Goodyear, 1998). The research supports that with the high level of burnout, compassion fatigue, and secondary traumatic stress, support is needed in the field regularly to keep people at their best (Maslach & Jackson, 1996).

The crisis clinicians identified that there is a lack of relationship between themselves and their supervisors, making it more difficult to establish consistent, supportive supervision. The clinicians identified that a relationship is important to them when working in crisis because it helps them receive and make sense of the feedback they receive. Ultimately, clinicians stated lack of support and lack of skill development because no one seemed to be taking the time to make sure it happened. A recent study done on professional school counselors' understanding of clinical supervision revealed that the experience of supervision, when done regularly, provided the counselors with support, enhanced skill development, increased confidence and job satisfaction, and

professional and personal identity development (Lambie, 2007). That study is reflective of the themes identified by the crisis clinicians as to what they are seeking in their own clinical supervision in crisis work.

I have worked in various positions and roles within the counseling field, but none have afforded me the opportunity for continuing growth in the way crisis intervention has. I knew immediately when pondering topics for this study that I would want to do an exploration of some aspect in the field of crisis. I have worked as a crisis clinician for many years, and through my time in that role I have had the great pleasure of seeing a piece of humanity that I never knew existed. I was able to flex muscles that I wasn't even aware I had until faced with the situation that required them the most. I worked in volatile situations and saw people potentially on the worst day of their life, and I was humbled to know true vulnerability. I carry that experience with me everywhere because as a counselor it taught me the need for flexibility and to never count people out, because they are resilient. I learned that from my team, and I learned it even more from the consumers I was proud to serve. I remember the moment I knew that supervision and support in crisis needed more exploration. I was responding to a crisis with my team and we responded tirelessly. There was so much need, and it required several weeks of attention and support. I proudly watched my team, my partners, offer to stay late and come in early to help. We gave up prior obligations and put our life on hold to respond to people in crisis. We heard and saw things we wished we had not and spent the little time off from that incident trying to help one another. I realized that it is hard to seek support from someone who is walking in it with you. I remember looking to one of the supervisors at the time and saying, "We are helping, but who is going to come and help us?" That

question has lived in me for years, “Who helps the helper? Whose responsibility is it?” Several years ago, when I became a supervisor, I felt that same struggle. I wondered if I was part of the problem and if there was more I could be doing to support the people who do this honorable work. This study demonstrated that there is more that needs to be done. This study gave those participants a platform to be heard and share their stories while trying to make sense of their experience. The study showed that these clinicians who are silently helping those in crisis are not alone.

When we think about trauma-informed care for clients, we remind each other that we never know the journey someone has walked before they get to our door. Each person has wrinkles from past experiences, and with the support of counseling we may be able to help straighten out those wrinkles with the client. Clinicians also have wrinkles, and with the support of supervision to raise some awareness and build skills and stay emotionally healthy, we can help straighten out those wrinkles.

## References

- Abas, P. (2008). *Loneliness and lived experiences of elderly individuals living independently: Hermeneutic phenomenological approach*. (Unpublished doctoral dissertation.) University of Rochester, Rochester, NY.
- American Counseling Association. (2005). ACA code of ethics. Alexandria, VA: Author.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- Arvay, M. (2001). Secondary traumatic stress among trauma counselors: What does the research say? *International Journal for the Advancement of Counseling*, 23, 283–293.
- Bandura, A. (1971). *Social learning theory*. New York: General Learning Press.
- Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society*, 84(4), 463–470.
- Bérci, M. E., & Griffith, B. (2006). Social studies methodology viewed as in a hermeneutic perspective. *Journal of Thought*, 41(4), 45–63, 166–167.
- Bernard, J. M., & Goodyear, R. K. (1998). *Fundamentals of clinical supervision*. Boston, MA: Allyn & Bacon.
- Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision* (4th ed.)

- Upper Saddle River, NJ: Pearson.
- Boscarino, J. A., Adams, R. E., & Figley, C. R. (2010). Secondary trauma issues for psychiatrists: Identifying vicarious trauma and job burnout. *Psychiatric Times*, 27(11), 24–26.
- Bride, B. E. (2004). The impact of providing psychosocial services to traumatized populations. *Stress, Trauma, and Crisis: An International Journal*, 7, 29–46.
- Bureau of Justice Statistics. (2011). *Intimate partner violence*. Washington, DC: U.S. Department of Justice.
- Caplan, G. (1964). *Principles of preventative psychiatry*. New York: Basic Books.
- Claudel, B. (1929). *L’oiseau noir dans le soleil levant* (The black bird in the rising sun). Paris, France: Gallimard.
- Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), *Existential phenomenological alternatives for psychology*. New York: Oxford University Press.
- Connolly, J. M., & Keutner, T. (1988). Interpretation, decidability, and meaning. In J. M. Connolly & T. Keutner (Eds.), *Hermeneutics versus science? Three German views* (1–67). New York: Plenum.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London: SAGE.

- Edwards, D., & Burnard, P. (2003). A systematic review of stress and stress management interventions for mental health nurses. *Journal of Advanced Nursing*, 42, 169–200.
- Eilfsen, M. (2011). Capture the unexpressed: Anecdote as a device in hermeneutic phenomenological research. *Indo-Pacific Journal of Phenomenology*, 11(1), 1–9.
- Everly, Jr., G. S., & Mitchell, J. T. (1999). *Critical incident stress management (CISM): A new era and standard of care in crisis intervention* (2nd ed.). Ellicott City, MD: Chevron.
- Everly, Jr., G. S., & Flannery, Jr., R. B. (1999). Crisis intervention: A review. *International Journal of Emergency Mental Health*, 1, 135–140.
- Fahy, A. (2007). The unbearable fatigue of compassion: Notes from a substance abuse counselor who dreams of working at Starbucks. *Clinical Social Work Journal*, 35, 199–205.
- Falvey, J. E. (2002). *Managing clinical supervision ethical practice and legal risk management*. Pacific Grove, CA: Brooks Cole.
- Figley, C. R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder*. New York: Bruner/Mazel.
- Figley, C. R. (2002). Compassion fatigue and the psychotherapist's chronic lack of self-care. *Journal of Clinical Psychology*, 58(11), 1433–1441.
- Gadamer, H.-G. (1977). *Philosophical hermeneutics*. Berkeley: University of California Press.

- Gadamer, H.-G. (1983). Hermeneutics as practical philosophy. In F. G. Lawrence (Trans.), *Reason in the age of science* (88–138). Cambridge, MA: The MIT Press.
- Gadamer, H.-G. (1998). *Truth and method* (2nd ed.). New York: Continuum. (Original work published 1960.)
- Giorgi, A. (1970). *Psychology as a human science: A phenomenologically based approach*. New York: Harper and Row.
- Guimond-Plourde, R. (1994). Le stress de l'écolier (The stress of the schoolchild). *The Canadian Nurse/l'Infirmière Canadienne*, 90(9), 40–43.
- Guimond-Plourde, R. (2004). *Le stress-coping chez des jeunes de 15 à 17 ans dans une perspective d'éducation pour la santé* (Stress-coping among young people of 15 to 17 years from the perspective of health education). (Unpublished doctoral dissertation.) Université du Québec à Montréal in association with Université du Québec à Rimouski.
- Health Visitor's Association. (1995). *Clinical supervision. Principles and process*. London: College Hill Press.
- Heidegger, M. (1962). *Being and time*. New York: Harper. (Original work published 1927).
- Heidegger, M. (1975). *Poetry, language, and thought*. New York: Harper & Row.
- Heidegger, M. (1985). *History of the concept of time*. Bloomington: Indiana University



- Press.
- Heidegger, M. (2000). *Introduction to metaphysics*. New Haven & London: Yale University Press.
- Hekman, S. (1984). Action as a text: Gadamer's hermeneutics and the social scientific analysis of action. *Journal for the Theory of Social Behavior*, 14, 333–354.
- Husserl, E. (1960). *Cartesian meditations: An introduction to phenomenology*. The Netherlands: Martinus Nijhoff.
- Husserl, E. (1964). *The phenomenology of internal time-consciousness*. Bloomington: Indiana University Press.
- Husserl, E. (1970). *The idea of phenomenology*. The Netherlands: Nijhoff.
- Hernández, P., Engstrom, D., & Gangsei, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. *Journal of Systemic Therapies*, 29(1), 67–83.
- Holloway, E. (1995). *Clinical supervision: a systems approach*. Thousand Oaks, CA: SAGE.
- Jackson-Cherry, L. R., & Erford, B. T. (2010). *Crisis intervention and prevention*. Upper Saddle River, NJ: Pearson Education.
- Kammerer, N., & Mazelis, R. (2006). Trauma and retraumatization. Paper presented at the After the Crisis: Healing from Trauma After Disasters Expert Panel Meeting,

- April 24–25, Bethesda, MD. Available at:  
[http://gainscenter.samhsa.gov/atc/text/papers/trauma\\_paper.htm](http://gainscenter.samhsa.gov/atc/text/papers/trauma_paper.htm)
- Kanter, J. (Ed.). (2004). Face to face with children: The life and work of Clare Winnicott. London: Karnac.
- Kuhl, J. (1981). Motivational and functional helplessness: The moderating effect of state versus action orientation. *Journal of Personality and Social Psychology*, 40, 155–170.
- Lambie, G. W., & Sias, S. (2009). An integrative psychological developmental model of supervision for professional school counselors-in-training. *Journal of Counseling and Development*, 87(3), 349–356.
- Lang, H. (1995). Hermeneutics and psychoanalytically oriented psychotherapy. *American Journal of Psychotherapy*, 49(2), 215–224.
- Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, 2(3), Article 3.
- Leichtentritt, R. D., & Rettig, K. D. (2001). Values underlying end-of-life decisions: A qualitative approach. *Health & Social Work*, 26(3), 150–159.
- Linesch, D. B. (1992). *Art therapists' experiences participating in research: A hermeneutic phenomenological exploration*. (Unpublished Ph.D. dissertation.) Union Institute & University, Cincinnati, OH.

- Maslach, C., Jackson, S., & Leiter, M. (1996). *Maslach burnout inventory manual* (3rd ed.). Palo Alto, CA: Consulting Psychologist Press.
- Matto, K., Betts, H. C., & Harrington, D. (2001). The Traumatic Stress Institute Belief Scale as a measure of vicarious trauma in a national sample of clinical social workers. *Families in Society*, 82(4), 363–371.
- McAdams, C. R., & Keener, H. J. (2008). Preparation, action, recovery: A conceptual framework for counselor preparation and response in client crisis. *Journal of Counseling and Development*, 86(4), 388–398.
- McCann, L., & Pearlman, L. A. (1990a). Constructivist self-development theory as a framework for assessing and treating victims of family violence. In S. Stith, M. B. Williams, & K. Rosen (Eds.), *Violence hits home* (305–329). New York: Springer.
- McCann, L., & Pearlman, L. A. (1990b). *Through a glass darkly: Understanding and treating the adult trauma survivor through constructivist self-development theory*. New York: Brunner/Mazel.
- McHugo, G. J., Caspi, Y., Kammerer, N., Mazelis, R., Jackson, E. W., . . . Kimerling, R. (2005). The assessment of trauma history in women with co-occurring substance abuse and mental health disorders and histories of interpersonal violence. *Journal of Behavioral Health Services & Research*, 32(2), 113–127.
- Merleau-Ponty, M. (1962). *Phenomenology of perception* (C. Smith, Trans.). London: Routledge & Kegan Paul. (Original work published 1945.)

- Minnes, P. (2001). My journey with Jake: A memoir of parenting and disability. *Canadian Psychology*, 42(4), 331–333.
- Nicholson, G. (1984). *Seeing and reading*. Atlantic Highlands, NJ: Humanities Press.
- Packer, M. J. (1985). Hermeneutic inquiry in the study of human conduct. *American Psychologist*, 40(10), 1081–1093.
- Packer, M. J., & Addison, R. B. (1989). *Entering the circle: Hermeneutic investigation in psychology*. Albany: State University of New York Press.
- Patterson, M. E., & Williams, D. R. (2002). *Collecting and analyzing qualitative data: Hermeneutic principles, methods, and case examples*. Champaign, IL: Sagamore.
- Roberts, A. R. (2002). Assessment, crisis intervention and trauma treatment: The integrative ACT intervention model. *Brief Treatment and Crisis Intervention*, 2(1), 1–21.
- Roberts, A. R. (2005). Bridging the past and present to the future of crisis intervention and crisis management. In A.R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (3rd ed., 3–34). New York: Oxford University Press.
- Shklar, J. N. (2004). Squaring the hermeneutic circle. *Social Research*, 71(3), 655–678.
- Smith, D. G. (1991). Hermeneutic inquiry: The hermeneutic imagination and the pedagogic text. In E. Short (Ed.), *Forms of curriculum inquiry* (187–209). New

York: State University of New York Press.

Trippany, R. L., White Kress, V. E., & Allen Wilcoxon, S. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development*, 82(1), 31–37.

Van Manen, M. (1984). Practicing phenomenological writing. *Phenomenology + Pedagogy*, 2(1), 36–69.

Van Manen, M. (1991). *The tact of teaching: The meaning of pedagogical thoughtfulness*. London, ON: Althouse Press.

Van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). London, Ontario: Althouse Press. (Original work published 1990.)

Van Manen, M. (Ed.). (2002). *Writing in the dark: Phenomenological studies in interpretive inquiry*. London, Ontario: Althouse.

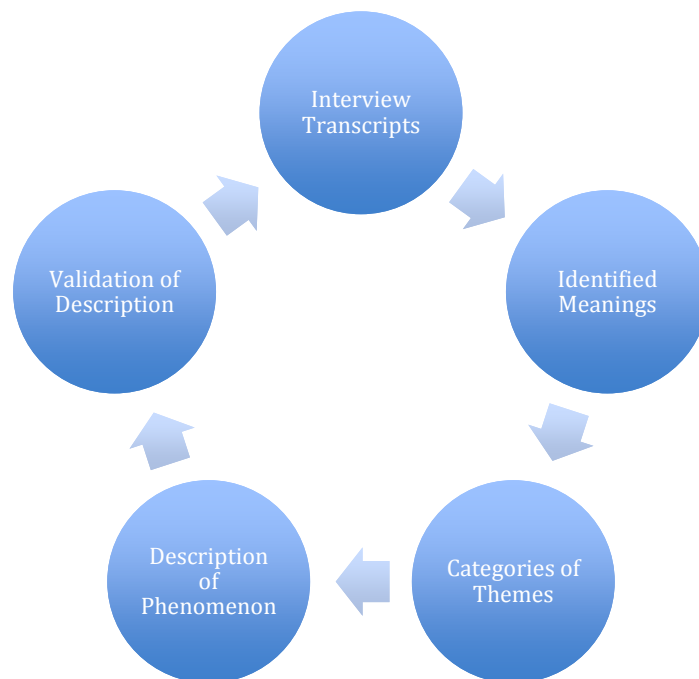
Van Manen, M. (2007). *Phenomenology of practice*. London, Ontario: Althouse.

Weiss, D. J., Dawis, R. V., & England, G. W. (1967). Manual for the Minnesota Satisfaction Questionnaire. *Minnesota Studies in Vocational Rehabilitation*, 22, 120.

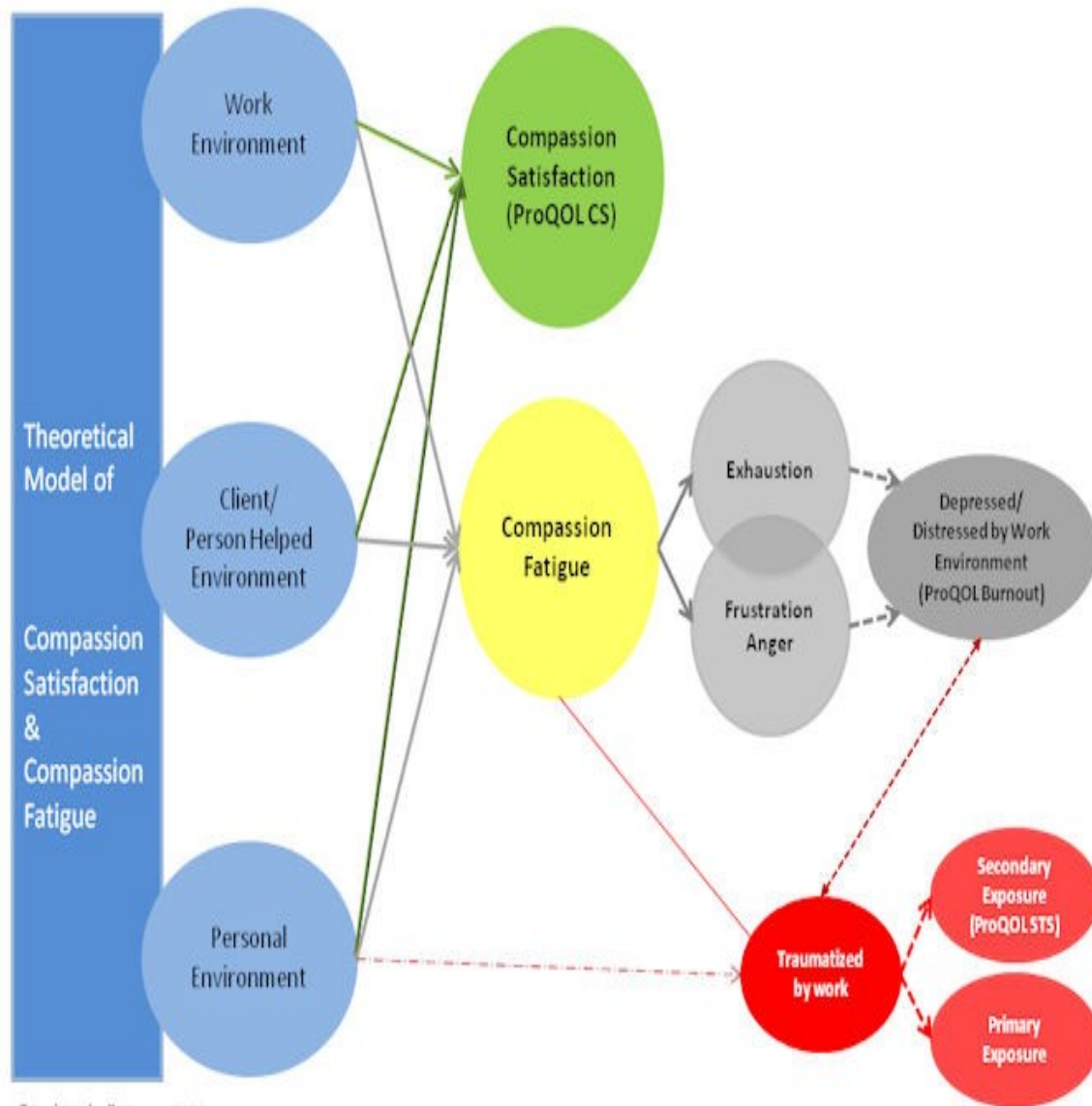
Welfel, E. R. (2002). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues*. Pacific Grove, CA: Brooks Cole.

Williams, A. M., Helm, H. M., & Clemens, E. V. (2012). The effect of childhood trauma, personal wellness, supervisory working alliance, and organizational factors on vicarious traumatization. *Journal of Mental Health Counseling*, 34(2), 133–153.

## Appendix A



## Appendix B

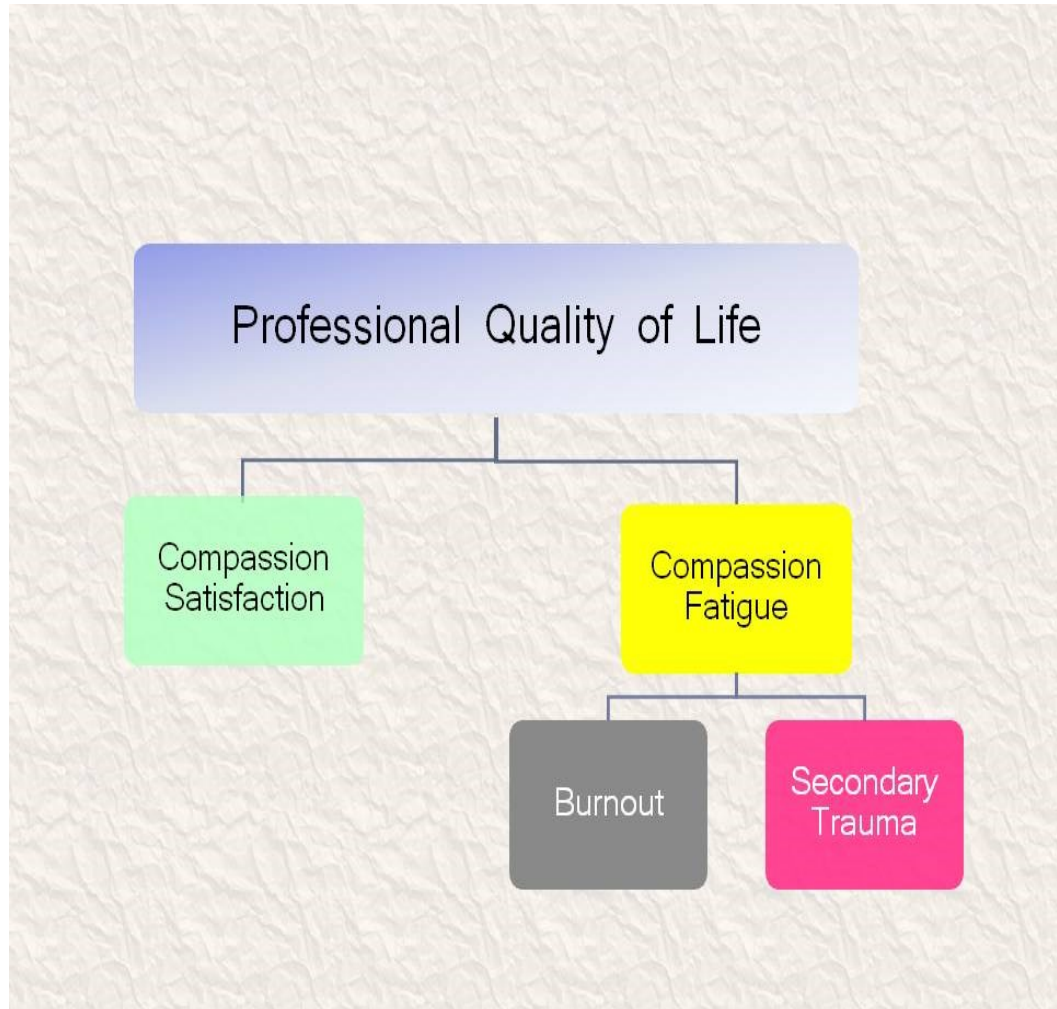


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## Appendix C



## Appendix D

### PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

#### COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

	1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
_____ 1. I am happy.					
_____ 2. I am preoccupied with more than one person I [help].					
_____ 3. I get satisfaction from being able to [help] people.					
_____ 4. I feel connected to others.					
_____ 5. I jump or am startled by unexpected sounds.					
_____ 6. I feel invigorated after working with those I [help].					
_____ 7. I find it difficult to separate my personal life from my life as a [helper].					
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].					
_____ 9. I think that I might have been affected by the traumatic stress of those I [help].					
_____ 10. I feel trapped by my job as a [helper].					
_____ 11. Because of my [helping], I have felt "on edge" about various things.					
_____ 12. I like my work as a [helper].					
_____ 13. I feel depressed because of the traumatic experiences of the people I [help].					
_____ 14. I feel as though I am experiencing the trauma of someone I have [helped].					
_____ 15. I have beliefs that sustain me.					
_____ 16. I am pleased with how I am able to keep up with [helping] techniques and protocols.					
_____ 17. I am the person I always wanted to be.					
_____ 18. My work makes me feel satisfied.					
_____ 19. I feel worn out because of my work as a [helper].					
_____ 20. I have happy thoughts and feelings about those I [help] and how I could help them.					
_____ 21. I feel overwhelmed because my case [work] load seems endless.					
_____ 22. I believe I can make a difference through my work.					
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].					
_____ 24. I am proud of what I can do to [help].					
_____ 25. As a result of my [helping], I have intrusive, frightening thoughts.					
_____ 26. I feel "bogged down" by the system.					
_____ 27. I have thoughts that I am a "success" as a [helper].					
_____ 28. I can't recall important parts of my work with trauma victims.					
_____ 29. I am a very caring person.					
_____ 30. I am happy that I chose to do this work.					

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## Appendix E

### *Self-Care Assessment Worksheet*

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve.

Using the scale below, rate the following areas in terms of frequency:

- 5 = Frequently
- 4 = Occasionally
- 3 = Rarely
- 2 = Never
- 1 = It never occurred to me

#### **Physical Self-Care**

- \_\_\_ Eat regularly (e.g. breakfast, lunch and dinner)
- \_\_\_ Eat healthy
- \_\_\_ Exercise
- \_\_\_ Get regular medical care for prevention
- \_\_\_ Get medical care when needed
- \_\_\_ Take time off when needed
- \_\_\_ Get massages
- \_\_\_ Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun
- \_\_\_ Take time to be sexual—with yourself, with a partner
- \_\_\_ Get enough sleep
- \_\_\_ Wear clothes you like
- \_\_\_ Take vacations
- \_\_\_ Take day trips or mini-vacations
- \_\_\_ Make time away from telephones
- \_\_\_ Other:

#### **Psychological Self-Care**

- \_\_\_ Make time for self-reflection
- \_\_\_ Have your own personal psychotherapy
- \_\_\_ Write in a journal
- \_\_\_ Read literature that is unrelated to work
- \_\_\_ Do something at which you are not expert or in charge
- \_\_\_ Decrease stress in your life

Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

## Appendix F

**Table 1**

### **Informant Demographics**

	<b>Age</b>	<b>Gender</b>	<b>Race</b>	<b>Years of Experience</b>
Informant #1	33	Female	Asian American	2.5
Informant #2	31	Male	African American	3
Informant #3	47	Male	Caucasian	5
Informant #4	29	Female	Caucasian	3.5
Informant #5	44	Male	Caucasian	4.5
Informant #6	34	Female	African American	4

## **Appendix G**

### Semi-Structured Interview Guiding Questions:

1. Talk a little about your role as a crisis clinician.
2. What are some ways you manage the stress and responsibilities of your job?
3. What has been your experience of clinical supervision?
4. What do you feel is the purpose of clinical supervision?
5. What are your expectations for how you would like to receive supervision?

## Appendix H

# DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

My name is Liz Sysak and I am a student from Duquesne University. I am conducting a study on crisis clinicians' experience of clinical supervision. The purpose of this study is to better understand the role that clinical supervision plays in supporting professional competence and personal well-being of the clinicians. In an attempt to collect information for this study I am seeking volunteer participants to engage in a 1 hour one on one interview. The participants will also be asked to engage in a small focus group with other volunteers to discuss themes that emerged from the interviews. The interviews and the focus group will be audio-recorded. The audiotapes will be locked in an office and used only by this researcher. No names or agencies will be identified in the study. After three years, all audiotapes and notes from the interviews and focus groups will be destroyed. Participants will be selected based on years of experience in the field (2-5), training in crisis response (CISM), and currently receiving some form of clinical supervision. Please contact me if you are interested in learning more about the study and/or if you are interested in participating in the study. Thank you for your time and consideration.

Liz Sysak ([sysak22@yahoo.com](mailto:sysak22@yahoo.com))  
412-417-8446

## Appendix I

Dear Participants,

Thank you for participating in the semi-structured interview and, more importantly, for sharing your personal experience, thoughts, beliefs, and meaning with me. If you would like, you may share your experience of being a part of this process by responding to the prompt below. You are welcomed to include additional thoughts and feelings, and any other comments you have on the process. You do not need to provide your name. These forms will be placed in a folder with the responses from other participants and will not be reviewed until the data collection is complete. You are not obligated to respond. Please place the completed or blank form in the envelope provided and return it to the researcher.

Thank you again for your time and consideration.

What was your experience like in the interview?

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As you reflect on the interview, do you have any specific thoughts?

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As you reflect on the interview, did or do you have any persistent feelings?

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How comfortable were you discussing this topic with the interviewer?

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## Appendix J

### Process of Creating Formulated Meanings (Individual Interviews)

Significant Statements (Van Manen's Existentials)	Formulated Meanings
We see people who need to talk, people who are getting abused, people who are ready to die and people who have just pulled the trigger, and everything in between. I do a lot of things at my job. I'm a crisis clinician and I do crisis intakes, crisis assessments, crisis support, mobile crisis, and phone crisis. (relationality)	Awareness that the job requires numerous skills
I meet the most interesting people every single day. I get to work with people from all walks of life. I go out on mobile crisis and we do what we can to stabilize people so they don't end up in the hospital or worse. (relationality)	Constantly encountering variety
I work with all kind of different people, mental health, no mental health, poor, rich you name it and I have worked with them. All ethnicities and genders, some people that I didn't realize existed in our town. I provide support and stabilization in the form of crisis intervention. I see people in some interesting and difficult moments. (relationality)	Understanding that there is multitasking
I get to work with all kind of people serious mental illness or not, and problem-solve with them. There is always something new and challenging. (relationality)	Awareness of wide range of people and illness
You have to bend yourself to fit whatever situation you walk into, you know? It requires you to adapt to whatever is happening and be ready to respond in an appropriate way. (corporeality)	Understands the importance adapting and adjusting
You have to be flexible, you know? If you can't be then you won't survive. There is no black and white, right or wrong, it's just a lot of grey. (spatiality)	Perception of crisis is abstract, people who need something concrete struggle
I am important and help people who can't see	Value in work, proud of the



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solutions . . . that is why I went into this field, to help and make a difference. I do that, that's something I can be proud of, so yeah that is what I do. (relationality)	effort and effects of crisis intervention, Believes in impact
I know when I go into work that day I am needed. (relationality)	A desire to the job because they are needed
I am valued and that is a good thing and can be rare for many people. (relationality)	Excitement for work because of value placed on it
I've made some imprint, several times along my way and I am proud of that. (spatiality, relationality)	Awareness that they are making a difference
I really believe in it, and feel so happy to be a part of all of this. I have cried with people and laughed with them. There have so many moments I will take with me forever; they have shaped me in so many ways. (relationality)	Excitement to be part of something that makes a difference
We have other calls that were just so amazing. You know? Where we made a difference. Helped someone or did something that could not have been if we had not been there. (relationality)	Understands the impact of the work
Oh definitely I didn't have to change much to do this work. It's in me. (corporeality)	Meant to do the work
We have other calls that were just so amazing. You know? Where we made a difference. Helped someone or did something that could not have been if we had not been there. (relationality)	Not everyone can do this job
I am grateful for that you know? It's like we were all meant to be together and do this kind of work, 'cause it isn't for everyone. It really isn't. (relationality)	As a team we were meant to do the work and it's nice for people to recognize that
The need to help, the want to help, that's in me. I can't shake that part of me. (corporeality)	Belief that they were meant to do the work. They know the value
I mean I lean on my team. I love my team. (laughs) Well I like love hate my team. We are tight but	There is a strong sense of "we"

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together a lot. So you know, dysfunctional family sometimes. (relationality)	The team is together and knows each other
I mean my team, you know, they know me. (relationality)	Comfort in team and partnership
And you know crisis is set up in teams. So you are never alone in that sense. Like if I needed something the best people to go to would be my partners anyway because they know me and my work much better than any supervisor anyway. We are a close group. I mean we see some really difficult things together so we are bonded by that if nothing else. (relationality)	Isolated from system which brings sense of team even closer
We are on our own, many of us feel that way. It is why we have such a sense of camaraderie. We have each other's backs at the end of the day. (relationality)	Team is a vessel for support
I felt like I was not in a great emotional place, but I used my team to deal with it. (corporeality)	Team brings a sense of trust
I know my team has my back. (relationality, corporeality)	Support from team
I mean I trust my partners, we're pretty close. (relationality, spatiality)	Team bond that fosters trust and support
When you see something that you are never prepared to see, death or total poverty and everything in between, and you're expected to be the "expert" it is terrifying. I am constantly aware that I am the one who has to make a decision here. I make a choice to tell the plane which direction it can go in and what if it is the wrong one? I mean, I guess I am not that important or powerful but still it leaves my heart beating just a little faster when I think about that. (corporeality, relationality)	They feel a large amount of responsibility on crisis calls which adds stress
I have to ignore the deceased individuals and stay with this guy and I am some stranger to him. I mean being there was really hard for me and my partner. I just felt sick. Do you know what I did after that call? I went on the next one.	Physical symptoms from a crisis call that linger after the call

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(corporeality)

But no one deserves to die like that, not someone who gave up so much for others. That was bad. I felt bad for him and worse I felt like a total failure. I didn't like my job that day. (relationality, corporeality)

Overwhelming sense of failure to do the job to do the strong emotions from the call

I remember the smells and the tears of all those people as they helplessly watched everyone and everything that they love burn in front of them. I remember feeling sick and like that feeling you get when your heart is in your throat and you just keep swallowing, or gulping rather so you don't lose it. Yeah, I remember that well. (corporeality)

Physical symptoms that were prevalent

Don't get me wrong there are days you walk out dead tired. Your body feels it because your emotions go through the ringer. (corporeality)

Physical reminder of the day and difficult calls

I had a crisis call last month where an infant died and I had to sit in the room with the mother while she was holding her deceased child. I mean people don't have to see that on a daily basis. No one ever said a word to me about that call. It just happened. No thank you, no are you ok, no let's talk about that case. That is a lot to carry. (corporeality, relationality)

The image of having to carry the emotions after that crisis were heavy for the participant

I walked home with that on that day. I carried it with me everywhere I went, literally felt it lingering in the pit of stomach. Maybe I still do in some ways. (corporeality, temporality)  
It is true I am always in crisis. I don't know how to step out of that role. (corporeality, temporality)

Lingering physical symptom

My problem is they are always busy, too. It's like everyone here has so much to do so it's hard to take a minute and really focus on much of anything. (temporality)

Struggle to disconnect from the role and responsibility of crisis clinician

Everyone is so busy, including them, that really doesn't, it just doesn't allow for time for

Little time for supervision as everyone is tending to tasks in

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supervision across the board. (temporality)	the moment
One hour, uninterrupted by crisis, to sit and be heard. (temporality)	Business of everyone in the system and unable to slow pace and do supervision No time in the system
We are all so freaking busy! Seriously, I have to remind myself to pee and sometimes I forget if I ate that day. We are non-stop. Everyone's crisis becomes our priority and our crisis. The thing is we ourselves, like are in our own crisis on some level and I am not sure we always manage it so well. (relationality, temporality)	
I gotta constantly watch myself for getting sad, angry, frustrated, anxious because that can ruin a call and impact safety too. We go call to call so the call I got at 8 a.m. is still with me at 2 p.m. and I have to be together and so does my partner. (corporeality, temporality)	The crisis becomes the team or the systems crisis because they are always on the go
Anyway, yeah, I mean it is a lot to juggle. I have no choice but to manage it because it can't spill out on my calls. (relationality, corporeality, spatiality)	Mindful of emotions that may impact the client or consumer in crisis
People talk about not carrying your baggage into work, for us it's actually dangerous to bring into work. (corporeality)	Balancing baggage and emotions in order to not influence call
There is no place for me on a crisis call. Counter-transference or whatever clinical term it is, it's really dangerous me, my partner, and the consumer. (relationality)	Safety risk if emotions or experience spill into crisis call
For me, I would like some supervision for me to work out some of my own stuff so it doesn't spill on calls. I am human and no matter how long I am in the field, I still get impacted by some things. (corporeality)	Identification of countertransference and its potential impact
I mean I can't be judging people. I need to respect the situation and the people regardless of my own values. I mean she was a young mom and was totally unprepared. But you know, me, um having my own baby right around that time, it was a trigger. (relationality, temporality)	Recognition to seek supervisory support to ensure clients or consumers are getting what they need on calls

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Well supervision here is sort of in the moment. I mean I sit with my supervisor maybe once every other month. Depends on the day. We are always on the go so it feels like its 10 minutes here or 5 minutes there. Everything is constantly in motion so sit down supervision is hard to come by. (temporality, spatiality)	Awareness that there needs to focus and attention on the crisis while managing clinicians' emotion
You know supervision is a rare commodity. I get it, in quick spurts, you know check-ins. (temporality)	Immediate supervision, in the moment
We need time for supervision. (temporality)	Check-in supervisions
Now it's rolling supervision I mean what can honestly be addressed in 15 minutes? (temporality)	No time is allowed for sit down supervision
Supervision should be consistent and structured, not haphazard. (temporality, spatiality)	Awareness that issues cannot be worked on given the time
It's annoying because when a supervisor stops you in the hallway or something and is like hey that case did you remember this or that and I feel like that is such a missed opportunity. Like take 25 minutes and sit with me. (temporality, spatiality)	Rushed Supervision
I mean it would be nice for supervision to last more than 10 minutes. You know those little check-ins or whatever, time blows by and you're thinking to yourself like what just happened? (temporality, spatiality)	Hallway supervision
Sit in like, an office, not the hallway or the parking lot where we happen to run into one another. I mean that's nuts. (corporeality, spatiality)	Quick supervision is led by supervisor agenda rather than clinician having an opportunity to talk
When things go wrong or if he catches me and needs administrative stuff. I go and get what I	Hallway supervision that is rushed and does not allow for

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need, but I know I'm missing clinical and professional growth without supervision. (relationality)	time to develop relationship
If I am still doing the same things I was doing a long time ago how could it still be right? (relationality)	Recognition that support is needed to grow
I feel uncomfortable in my own skin sometimes on calls now. I feel like a fraud. (corporeality)	Concern over skills not being ok for the work due to lack of supervision
But I guess I'm doing alright if I haven't been pulled in or anything. Like I guess I know what I am doing for the most part because otherwise they would tell me. (relationality)	Unsure of skills and lacking confidence due to no supervision
Yeah, I mean I would assume if things were bad we would know about it. (relationality)	Not having supervision means they haven't done anything wrong
I know as a supervisor myself that I tend to pay more attention to the ones who need help, so the fact that I am not getting as much attention is a sign that I am ok. (relationality)	The supervisors responsibility is to let them know if things are wrong
I get supervision if I absolutely need it. I am not sure how much I need at this point professionally (relationality)	Lack of supervision means they are doing well
It would be nice to have someone be like, hey you ok? Everything ok, or how was that call? I don't know. (relationality)	Confidence in skills due to minimal supervision, people who struggle need supervision more
I guess ultimately supervision should include team supervision, case reviews, and probably some self-care stuff. I mean we see so many people, so many patients a day that the supervisor has no idea of all the people we come in contact with on a daily basis let alone a weekly one. (relationality, spatiality)	Check-in on well-being

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It would help us debrief and process things instead of letting them build up. We could talk about cases and self-care stuff, I mean at least so people know. (corporeality, relationality)	Self-Care and liability of client contact
I would like for people to acknowledge the lack of self-care and help me identify when it's an issue because ultimately I am I clinician mode and I can't see myself that way. (corporeality)	Supervision could be used for developing personal well-being
I don't think I have ever been asked, hey how are feeling, that call must have been tough or are you feeling burned out because I noticed you were over shift the last two weeks. Even if there is little he can do for me, it would be nice to be asked to know he knows and has some level of concern. (corporeality, relationality)	Awareness that supervision may help increase insight into poor self-care habits
Every once in a blue moon he might check in and say something like, 'things ok'? I take that as a check in on my self-care. For me I think it is an ethical obligation for supervisors to do this. I mean we are on the front line. I would like some space to talk about my emotions. (corporeality, spatiality, relationality)	Feeling drained and not refreshed for work could be helpful to increase awareness
I want to manage stuff. I want supervision to at least acknowledge that this job can take its toll on people. Supervision to me at least would be my time. I don't want to feel like a crybaby that a call touched me in some way I want to feel like I'm not alone and that this work is hard. (corporeality, relationality)	Time to talk about emotions that may be complex and challenging for clinicians
I think that if I had supervision or just someone here to mentor me I would be able to discuss cases and really talk about my emotions so I could compartmentalize. Instead, it's one call after the other". (corporeality, relationality)	Acknowledgment of difficult nature of job and safety to talk about tough calls
I think that supervision would be helpful if I could really discuss cases and my emotions around it. I can let go of things once I have that moment and get some perspective. (corporeality, relationality)	Recognition of supervision to give an outlet for emotions that are leftover from calls

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How do you sit with someone who barely knows what you are even about and give them feedback or support? I think supervision should have professional development and like personal, not counseling or anything but I guess self-care and management. I mean without someone helping with my skills they won't grow. (relationality)

Self-care or personal well-being check in would help gain insight and perspective to continue doing job

How do you sit with someone who barely knows what you are even about and give them feedback or support? I think supervision should have professional development and like personal, not counseling or anything but I guess self-care and management. I mean without someone helping with my skills they won't grow. (relationality)

Skill development is important but challenging because the supervisors don't know the workers

I never talk about my development or professional things like that. I never know where I stand. In terms of my skill level. (corporeality, relationality)

Awareness that clinicians don't know skill level due to lack of evaluation

With all the stuff we have to see, knowing that maybe my skills are not being developed as should is really hard to swallow. (corporeality, relationality)

Supervision is not evaluating or growing skills for clinicians

It would give them an opportunity to discuss cases and determine skill level. (relationality, temporality)

Clinicians unaware of skill level

Hmm, well actually the last time I sat with my supervisor was when I had to go over my review. We have reviews; you know yearly, to make sure we are keeping up with all the requirements of the job. I had my review two months ago. We sat down and went over the past year and skills that I have done well with and things I need improvement on. (spatiality, temporality, relationality)

Supervisors evaluating skills once a year but not following up on the skills throughout the year



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I mean I like my supervisor just fine but it is kind of crazy 'cause those are the guys that evaluate you for like salary increase and stuff and they probably know really little about me. That's crazy to think about. (relationality)

Supervisors evaluating clinicians work but they do not know the work or meet regularly

My supervisor doesn't really know that much about me. (relationality)

Lack of insight or knowledge of clinicians seems unbalanced for supervisors to evaluate

It can be frustrating to not get it, but I also don't let my frustration get much of me because I get it. There are a lot of us. One supervisor, you do the math. It can be hard and as a more senior professional, I get it. (corporeality, relationality)

Business of system prohibits staff from receiving supervision as well as supervisors receiving it

You know this thing, this supervision piece it, it really should be a, a requirement we take seriously, but I know well enough that it isn't and at times it is almost impossible to actually implement. The organization needs it, you know. It is important for the whole structure. Who is supporting everyone else? I mean that is scary to think that the people who should be supporting me aren't getting supported either. It's a bad cycle. (temporality, relationality)

Awareness that the supervisors are not getting the supervision or support needed. The system is not supporting the members

I know how busy the supervisors are. I get it. I mean the system is not set up to support itself at all. That isn't a judgment that is just a fact. I mean the supervisors aren't getting supervision either. (temporality, relationality)

Supervision is difficult for clinicians because it isn't happening on any level

## Appendix K

### Process of Developing Meanings and Themes, Individual Interviews

Formulated Meanings	Theme Clusters	Emergent Themes
Awareness that the job requires numerous skills	Multitasking with numerous roles/different hats	Flexibility of role in crisis
Constantly encountering variety		
Understanding that there is multitasking		
Awareness of wide range of people and illness		
Understands the importance adapting and adjusting	Excitement and desire to do crisis work because they know they are making a difference	Pride and passion for work
Perception of crisis is abstract, people who need something concrete struggle		
Value in work, proud of the effort and effects of crisis intervention, believes in impact		
A desire to the job because they are needed		
Excitement for work because of value placed on it		
Awareness that they are making a difference		
Excitement to be part of something that makes a difference		

Understands the impact of the work			
Meant to do the work	Belief that they are unique because they are meant to do the work making it more valuable	Value in work and role	
Not everyone can do this job			
As a team we were meant to do the work and it's nice for people to recognize that			
Belief that they were meant to do the work. They know the value			
There is a strong sense of "we"	Trust, confidence, and support in team work and partners	Team bonding	
The team is together and knows each other			
Comfort in team and partnership			
Isolated from system which brings sense of team even closer			
Team is a vessel for support			
Team brings a sense of trust			
Team bond that fosters trust and support			
They feel a large amount of responsibility on crisis calls which adds stress	Emotionally and physically draining work experience that lingers	Emotional and physical reactions to crisis events	
Physical symptoms from a crisis call that linger after the call			
Overwhelming sense of			

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failure to do the job to do the  
strong emotions from the call

Physical symptoms that were  
prevalent

Physical reminder of the day  
and difficult calls

The image of having to carry  
the emotions after that crisis  
were heavy for the participant

Lingering physical symptom  
Struggle to disconnect from  
the role and responsibility of  
crisis clinician

Little time for supervision as  
everyone is tending to tasks in  
the moment

Business of everyone in the  
system and unable to slow  
pace and do supervision

No time in the system

The crisis becomes the team  
or the systems crisis because  
they are always on the go

Minimal time  
because the system  
is “putting out fires”  
and in their own  
crisis so not  
managing the bigger  
picture

Perpetual crisis mode

Mindful of emotions that may  
impact the client or consumer  
in crisis

Balancing baggage and  
emotions in order to not  
influence call

Safety risk if emotions or  
experience spill into crisis call

Crisis calls trigger a  
lot of emotions and  
clinicians are aware  
of how they could  
potentially interfere  
with the work

Countertransference

Identification of

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countertransference and its  
potential impact

Recognition to seek  
supervisory support to ensure  
clients or consumers are  
getting what they need on  
calls

Awareness that there needs to  
focus and attention on the  
crisis while managing  
clinicians' emotion

Immediate supervision, in the  
moment

Check-in supervisions

No time is allowed for sit  
down supervision

Awareness that issues cannot  
be worked on given the time

Rushed supervision,  
Hallway supervision

Quick supervision is led by  
supervisor agenda rather than  
clinician having an  
opportunity to talk

Hallway supervision that is  
rushed and does not allow for  
time to develop relationship

Recognition that support is  
needed to grow

Concern over skills not being  
ok for the work due to lack of  
supervision

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Rushed supervision.  
No set time or  
structured  
supervision

Brief supervision  
(supervision on the go)

Unable to develop  
skills due to lack of  
supervision. Lacking  
confidence in skill  
level and  
development

Lack of supervision leads to  
questioning skills

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Unsure of skills and lacking confidence due to no supervision

Lack of supervision means skills must not need to be developed.

Lack of supervision leads to confidence in skills

Not having supervision means they haven't done anything wrong

Supervision is for when you are doing something wrong

The supervisors responsibility is to let them know if things are wrong

Lack of supervision means they are doing well

Confidence in skills due to minimal supervision, people who struggle need supervision more

Check-in on well-being

Self-care and liability of client contact

Supervision could be used for developing personal well-being

Awareness that supervision may help increase insight into poor self-care habits

Feeling drained and not refreshed for work could be helpful to increase awareness

Time to talk about emotions that may be complex and challenging for clinicians

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Supervision should be used to help clinicians so that they can recharge the battery

Supervision for self-care

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Acknowledgment of difficult nature of job and safety to talk about tough calls

Recognition of supervision to give an outlet for emotions that are leftover from calls

Self-care or personal well-being check in would help gain insight and perspective to continue doing job

Skill development is important but challenging because the supervisors don't know the workers

Awareness that clinicians don't know skill level due to lack of evaluation

Supervision is not evaluating or growing skills for clinicians

Clinicians unaware of skill level

Supervisors evaluating skills once a year but not following up on the skills throughout the year

Supervisors evaluating clinicians work but they do not know the work or meet regularly

Lack of insight or knowledge of clinicians seems unbalanced for supervisors to evaluate

Supervision has a responsibility to assess and evaluate skills to let clinicians know level and goals so there is an area of focus

Evaluative supervision

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Business of system prohibits staff from receiving supervision as well as supervisors receiving it

Awareness that the supervisors are not getting the supervision or support needed. The system is not supporting the members

Supervision is difficult for clinicians because it isn't happening on any level

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Supervisors aren't getting support because the system is in crisis and too busy to give and receive supervision

Supervision for supervisors (systemic support)



## Appendix L

### Themes from Individual Interviews

- **Collective sense of pride and passion for crisis work** (*pride and passion for crisis work*)
  - Clinicians were generally very enthusiastic about the work they did.
  - Generated a lot of excitement while discussing their role.
- **Value in the work that is done on a daily basis** (*value in the work*)
  - Clinicians generally identified that they were “meant” to do this job.
  - Clinicians believed that their role was important and made an impact.
- **Strong sense of “team” and partnership/bonding among clinicians** (*sense of team in crisis work*)
  - Trust and comradery among partners and team.
  - Feedback/peer supervision existed among the team.
- **A job that requires constant flexibility** (*flexibility needed in crisis work*)
  - Clinicians go from call to call.
  - Clinicians describe their job as wearing many hats and doing whatever the situation requires.
- **Emotionally and physically exhausting crisis calls/events** (*emotional and physical exhaustion from calls*)
  - Some recalled specific incidents that were challenging and draining.
  - Clinicians generally discussed the need to be completely present for all-consuming crisis calls.
- **Always in “crisis mode,” struggle to disconnect from work** (*constant crisis mode*)
  - Due to the intensity and volume of calls clinicians found it difficult to separate from being a clinician.
  - Many described “carrying” calls with them after work.
- **Countertransference on calls, calls that trigger clinicians** (*countertransference*)
  - Clinicians identified feeling vulnerable at times during certain crisis events that triggered the clinicians.
  - Clinicians identified emotions and experiences “spilling” into crisis calls where the consumer should always be the focus.
- **Supervision occurring “in the moment,” not a sit-down debriefing** (*supervision in the moment*)
  - Clinicians talked about brief moments with supervisor regarding certain situations, but no time to sit one on one for an hour and have clinical supervision.
- **Lack of supervision leads to questioning skills and professional development** (*lack of supervision makes clinicians question skills*)
  - Clinicians discussed their skills declining due to lack of supervision.
  - Clinicians identified a lack of growth, professionally and personally, due to insufficient supervision.

- **Lack of supervision reflects that there is not as much need for supervision** (*lack of supervision means clinicians are doing well because supervision is for those who struggle clinically*)
  - Clinicians identified the supervisor only focuses on people who need more assistance.
  - Clinicians discussed the lack of supervision meaning that the clinicians' skills were ok and no feedback was needed at the moment.
- **Supervision expectations include: self-care, professional development, case consultation, and team building** (*supervision for self-care*)
  - Clinicians identified that it would be nice to have supervision to discuss cases, grow in skills, check-in on well-being and the emotional baggage that might result from a crisis and team supervision to work with partners better.
- **Lack of supervision leads to questioning about evaluative component of skill development and progress** (*evaluation in supervision*)
  - Clinicians identified that part of supervision is to identify skills/competencies and evaluate clinicians' progress.
  - Clinicians challenged how this could be done fairly without regular supervision and monitoring of skill development.
- **Supervision is a system problem because supervisors aren't getting supervision either** (*supervisors not getting supervision*)
  - Clinicians shared that because of the nature of the work everyone is busy and not getting supported from their supervisor, including supervisors.
  - Systemic support is not happening because the system is operating as crisis clinicians, managing the moment and not the root of the problem.

## Appendix M

### Process of Creating Formulated Meanings (Focus Group)

Significant Statements	Formulated Meanings
People at my agency always refer to us as the “cocky group” and I take that as a compliment because we are confident in what we do and we are good at it.	Demonstrate confidence and value
I think that our work is really important, and I think my skills that I naturally have fit with the field.	
Team is what makes the ship run.	Group has strong understanding and appreciation of team work
We kind of already formed a team here!	
I mean they keep me sane. They help me make sure, I’m like on the right track. They know my work and my mood.	
I think that is why we are in teams, since supervision isn’t happening at least we have our partners.	
We could talk to a supervisor if we absolutely had to but things are constantly moving, too. I have felt sick to my stomach after some calls. Sleepless nights, the whole nine. Like what people don’t get is that there isn’t a time. We are always busy.	Emotional reactions on crisis calls and how they deal with that impact
There are days I would like to forget but it is a challenge But like if you don’t develop a thick skin you can’t survive.	
I think the thick skin is necessary	Certain characteristics needed to be a crisis clinician, similarities of crisis culture
I mean the point of supervision is someone who is trained and outside of the situation who can provide like, I don’t know guidance of some sort.	

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I think countertransference can happen to both of us on a crisis call and if that is the case then we're both screwed because no one is aware enough to make a judgment. That has to happen in supervision and it doesn't.

Clinicians' understanding of supervision and its components

Yeah, on some level actually, should supervision be more for the people who are good, so they can like stay good?

My supervisor will never know me like my team does anyway.

For me, self-care is first on that list. I mean at some point without that none of the other stuff matters. Like, heard you saw someone die today. Must have been rough.

I need to know that self-care is a priority in my eyes and my supervisors. Like if you want me to keep running and doing my job you have to refuel me in some way. Some days I feel like I am running on empty.

I want to talk about my cases, good and bad, I want to grow in my skill set, I want to work better with my partner, and I want to make sure I am ok so I'm not carrying stuff with me.

I think it's unethical to truly evaluate someone who you haven't met with or monitored at all. Like, not ok. I mean that is me judging a consumer based on their diagnosis without getting to know the whole person first.

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## Appendix N

### Meanings and Emergent Themes, Focus Group

Formulated Meanings	Cluster Themes	Emergent Themes
Demonstrate confidence and value	Clinicians' perception of themselves	Clinician confidence
Group has strong understanding and appreciation of teamwork	Group's perception of team is that it is effective and helpful	The necessity of teamwork in crisis
Emotional reactions on crisis calls and how they deal with that impact	Clinicians' management of work	Clinicians' self-care process in crisis
Certain characteristics needed to be a crisis clinician, similarities of crisis culture	Clinicians' perception of common and necessary traits to do effective work	Crisis culture
Clinicians' understanding of supervision and its components	Clinicians' perception of reason and purpose of supervision	Experience of clinical supervision in crisis

**Appendix O**

# **DUQUESNE UNIVERSITY**

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

## **CONSENT TO PARTICIPATE IN A RESEARCH STUDY**

**TITLE: The Lived Experience of Crisis Clinicians as they Perceive Clinical Supervision**

**INVESTIGATORS:**

Dr. William Casile, Advisor  
Duquesne University  
Miss Elizabeth Sysak principal investigator  
Duquesne University

101C Canevin Hall  
Duquesne University  
Pittsburgh, PA 15282  
412.396.6112

**PURPOSE:**

You are being asked to participate in a research project that seeks to explore the experience of clinical supervision as a crisis clinician. You will be asked to participate in a focus group among your peers to discuss some of the themes identified from the one- on- one semi-structured interviews. The focus group will be a 1 hour audio-recorded interview. None of the themes discussed have any identifying information of individual's. The group will discuss the accuracy as well as elaborate on the themes identified by the researcher.

This will be all that is asked of you.

**RISKS AND BENEFITS:**

Although there are no direct benefits in your participation in this study, you will have the satisfaction of knowing that your participation will contribute to the research literature on clinical supervision and professional well-being in crisis work. By participating in the research project it is anticipated that there will be minimal risks no greater than those encountered in everyday life. Due to the nature of focus groups confidentiality cannot be guaranteed as the researcher has no control over the other participant's actions.

**COMPENSATION:**

My participation in the project will require no monetary cost to me. There will be no monetary compensation for participation in this study. I have the right to withdraw at any point during the study.

**CONFIDENTIALITY:**

Every member that participates in the focus group will sign off on confidentiality waivers. The focus group interview includes other participants and therefore complete confidentiality cannot be guaranteed because the researcher cannot control what the participants say after the interview. All original data will be destroyed five years following the completion of the research project. I understand that my name will not be revealed in any description of publication of this research. Therefore I allow the research to be published for scientific purposes.

**RIGHT TO WITHDRAW:**

I understand I am under no obligation to participate in this study. I am also free to withdraw my consent to participate at any time. If I choose to withdraw from the study my data will not be included in the data analyses.

**SUMMARY OF RESULTS:**

A summary of the results of this research can be supplied to me, at no cost, upon request.

**VOLUNTARY CONSENT:**

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Dr. William Casile (412-396-6112), Miss Elizabeth Sysak (412-417-8446), or Dr. Linda Goodfellow, Chair of the Duquesne University Institutional Review Board (412-396-1151).

By signing the consent form I acknowledge my agreement to participate in this study.

Participant Name (please print): \_\_\_\_\_

Participant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Researcher's Name: \_\_\_\_\_

Date:

Researcher's Signature: \_\_\_\_\_

Date:



**Appendix P**

# **DUQUESNE UNIVERSITY**

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

## **CONSENT TO PARTICIPATE IN A RESEARCH STUDY**

**TITLE:** The Lived Experience of Crisis Clinicians as They Perceive Clinical Supervision

**INVESTIGATORS:**

Dr. William Casile, Advisor  
Duquesne University  
Miss Elizabeth Sysak MsEd, Principal Investigator  
Duquesne University

101C Canevin Hall  
Duquesne University  
Pittsburgh, PA 15282  
412.396.6112

**PURPOSE:**

You are being asked to participate in a research project that seeks to explore the experience of clinical supervision as a crisis clinician. Specifically, you are asked to complete a survey containing demographic items and questions about your years of experience in the field of crisis intervention as well as the training and preparation you have received to perform your job. You will be asked to participate in a 1 hour, audio-recorded, semi-structured one on one interview with the researcher in order to better understand individual experience with clinical supervision as a professional in the field of crisis intervention.

**This will be all that is asked of you.**

**RISKS AND BENEFITS:**

Although there are no direct benefits in your participation in this study, you will have the satisfaction of knowing that your participation will contribute to the research literature on clinical supervision and professional well-being in crisis work. By participating in the research project it is anticipated that there will be minimal risks no greater than those encountered in everyday life.

**COMPENSATION:**

My participation in the project will require no monetary cost to me. There will be no monetary compensation for participation in this study. I have the right to withdraw at any point during the study.

**CONFIDENTIALITY:**

Confidentiality will be strictly maintained, as my name will never appear on my interview. The researcher will assign numbers to each participant to ensure privacy of all volunteers. I understand that any information obtained about me from this research will be kept confidential at all time by means of password-protected computers accessible only by the researchers. All original data will be destroyed five years following the completion of the research project. I understand that my name will not be revealed in any description of publication of this research. Therefore I allow the research to be published for scientific purposes.

**RIGHT TO WITHDRAW:**

I understand I am under no obligation to participate in this study. I am also free to withdraw my consent to participate at any time. If I choose to withdraw from the study my data will not be included in the data analyses. I may withdraw from this study at any time by notifying the researcher via email or phone that I no longer wish to participate.

**SUMMARY OF RESULTS:**

A summary of the results of this research can be supplied to me, at no cost, upon request.

**VOLUNTARY CONSENT:**

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Dr. William Casile (412-396-6112), Miss Liz Sysak (412-417-8446), or Dr. Linda Goodfellow, Chair of the Duquesne University Institutional Review Board (412-396-1151).

By signing the consent form I acknowledge my agreement to participate in this study.

Participant Name (please print): \_\_\_\_\_

Participant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Researcher's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Appendix Q**

### **Informant 1 Transcription**

**Interviewer:** Thanks for meeting with me, I really appreciate it. Um, and now that we have reviewed all the confidentiality is it ok if we dive right in?

**Informant 1:** Yep, of course. Let's do it.

**Interviewer:** Ok great. Well then if it's ok with you could you talk a little about your role as a crisis clinician here? What all does that entail?

**Informant 1:** Well I am a crisis clinician so that means I am a first responder. So basically anything that people could consider like a crisis in their lives, I could have to respond. It's a lot of different stuff. We see people who need to talk, people who are getting abused, people who are ready to die, and people who have just pulled the trigger and everything in between. I do a lot of things at my job. I'm a crisis clinician and I do crisis intakes, crisis assessments, crisis support, mobile crisis, and phone crisis. On any given day I do one or all of those different things. It's exhausting but exciting!

**Interviewer:** Wow, so it covers a lot of different things. It seems like you wear many different hats in your role. I mean it's a lot, how do you juggle all those responsibilities and hats?

**Informant 1:** (laughs) I know! It is a lot when you say it out loud, but when you are doing it, it's just, I don't know. It's just what it is, you know? Like when I talk about my work no one seems to get it unless you've walked it. It seems so strange to people, they're like you do what? We always say we should have a reality show, because it would be hilarious. Anyway, yeah, I mean it is a lot to juggle. I have no choice but to manage it because it can't spill out on my calls. The consumer is always my priority;

sometimes I just wish I was someone's priority at my job. That sounded dramatic, sorry. But seriously it's tough when you put others first constantly and you realize you're not first in your boss or really anyone's eyes. That even feels uncomfortable to say out loud. I mean and maybe it's out of business. We are all so freaking busy! Seriously, I have to remind myself to pee and sometimes I forget if I ate that day. We are nonstop.

Everyone's crisis becomes our priority and our crisis. The thing is we ourselves, like are in our own crisis on some level and I am not sure we always manage it so well. The calls are crazy intense and take everything you have and you take a breath, barely, and then do the next one. When we get called in, it's nuts. I mean we are on someone else's like turf, you know? So I have to go in and I don't even command the attention when I'm there, it's like when I get there all eyes are on us and we have to do something. I'm not sure if I am making sense. I have to balance a lot at one time on calls. Sometimes you can get claustrophobic and it's hard to breathe because suddenly everything gets a lot smaller when you are the center of attention and people are expecting you to do something you know. I'm like an air traffic controller. I have to manage everyone's planes and put out every potential fire. Sometimes we have close calls that are turbulent and leave you sweating and other times the ride is smooth. It's just you and your partner and this event trying to get these planes to safety, whatever safety is for that person. It's a lot of pressure and a huge amount of responsibility.

**Interviewer:** There is a sense of team in what you are talking about, you know that very few people can understand the dynamics and the pressure.

**Informant 1:** Yeah, for sure. I mean I trust my partners, we're pretty close.

**Interviewer:** I am hearing and seeing that you take your job very seriously and place a lot of value on what you do.

**Informant 1:** For sure.

**Interviewer:** You used the analogy of an air traffic controller, which is pretty powerful to me. When I think air traffic controller I think they must have a lot of stress because they are handling a lot in a short time frame and at the end of the day, you know, it's human life.

**Informant 1:** You have no idea how much stress I carry with me every single day. When you see something that you are never prepared to see, death or total poverty and everything in between, and you're expected to be the "expert" it is terrifying. I am constantly aware that I am the one who has to make a decision here. I make a choice to tell the plane which direction it can go in, and what if it is the wrong one? I mean, I guess I am not that important or powerful but still it leaves my heart beating just a little faster when I think about that.

**Interviewer:** I can only imagine. Because the other thing about the air traffic controller is that it impacts not just one entity. I mean it's not just one plane, its other planes and their course and the people inside the plane and all their families and loved ones. It is so much bigger than one person. It's probably extremely important for the air traffic controller to remain completely present and focused.

**What would you say about your focus on a crisis call?**

**Informant 1:** I think or at least I hope that when I'm on a call, I'm there. I mean it's not safe to zone out for me or them. People talk about not carrying your baggage into work, for us it's actually dangerous to bring into work. Like I have to have some control on that

stuff so I can be there and really pay attention. Which is kind of hard like if I wake up in the morning and I am having a bad day I'm already stressed 'cause I know I am working that day and I have to figure out what to do with that. There is no place for me on a crisis call. Countertransference or whatever clinical term it is, it's really dangerous me, my partner, and the consumer.

**Interviewer: I want to really highlight the word you used earlier because it stood out to me. You used the word “priority” and it kind of made me think about, like the fact that maybe no one is looking out for you or putting you first. Is that what you meant?**

**Informant 1:** Um, yeah, I guess so. Like I just feel really isolated sometimes. I try to put the consumer first, no matter what. At the expense of me sometimes. Which is not smart by the way, but true. I have my partners, they get it because they live it. Maybe everyone feels that way. I just know that we are a group of unique individuals who experience some really screwed up downright sad stuff. We count on each other for feedback and to keep one another in check because no one else does.

**Interviewer: I really appreciate you sharing all of this with me and if it's ok I would like talk a little about supervision. What has been your experience of clinical supervision in this role?**

**Informant 1:** You said it was, but like this is confidential right? I mean I don't want people to get in trouble or anything.

**Interviewer: I totally respect that and um yes of course this is confidential, but if you are uncomfortable at all you just let me know and we can stop or if there are questions you don't want to answer just tell me.**

**Informant 1:** No, no. I'm cool. (laughs) I'm always paranoid, that is my nature. Honestly, I get administrative supervision for lates or paperwork, but am not sure I have had like real clinical supervision in months. Supervision is for when you like, get in trouble or something. That is when I see my supervisor the most. Otherwise, it's hard to say. I can't tell you the last time I sat with my supervisor and really talked with him about me or about cases. It's so frustrating to be asked to do this work, which is so intense, and have no one know what you're doing. I mean isn't there a liability in that? I just don't know. I get "supervision" it just sucks. That was harsh. Doesn't make it any less true.

**Interviewer:** That has to be difficult because you just spent a good amount of time talking about the intensity of the work and your emotions so to not be fully receiving must be tough. What are your expectations for supervision? What would it look like?

**Informant 1:** Last year I had one of the most difficult days I have ever had there. I remember it, it was a Tuesday. I was going to be off for 3 days after that shift. My partner and I get called into an active scene, meaning police and EMS are still on site and it's probably messy. We get there, and it's this guy who is sobbing over a dead body. I don't want to be graphic but that's how it was. The guy's wife killed the kid and then took her own life. It was a really bad scene. I mean your heart broke for the whole situation. The police and EMS are trying to deal with the coroner and they wanted us to talk with him. Like seriously this guy was a mess, it was really hard. I am standing there trying to comfort this man who just lost his whole world and he is just broken. You know? There is nothing I can say or do that will change the outcome so I am just supporting him. I'm trying to make sure calls are getting made to his other family so that he won't be alone. I



have to ignore the deceased individuals and stay with this guy and I am some stranger to him. I mean being there was really hard for me and my partner. I just felt sick. Do you know what I did after that call? I went on the next one.

**Interviewer: You went to another call right after you left?**

**Informant 1:** Yeah! We get the next call like we didn't just walk away from a crime scene. And the best part, or really the worst part, was that the call was some guy who beat up his wife. I mean is that polar opposite or what? Here I am walking off an emotionally draining moment to a call where a husband is a complete jerk. I wanted to get authoritative and be like do you not know what you have?! Some guy just lost his wife and you're sitting here abusing yours. Of course I didn't because my role was to respond to the wife while the police handled him. It's just kind of crazy. I mean, that, that scenario, that is what supervision would be great for. I could use some time to deal with that.

**Interviewer: What a difficult and trying day. Managing not only one but two crises that really tested the limits emotionally. I had, um, asked you about your expectation for supervision, what would it have been for that situation?**

**Informant 1:** Yeah, I just wish he checked in with me. Like at the very least a check in. I never got that moment. I mean I guess in some twisted way I am getting it now with you. I walked home with that on that day. I carried it with me everywhere I went, literally felt it lingering in the pit of stomach. Maybe I still do in some ways.

**Interviewer: Thank you for sharing that story with me, it could not have been easy. I hope you are in a better place with it. I know that working with people in vulnerable moments though trying on us are so helpful to the consumer.**

**Informant 1:** I totally agree. I know that guy appreciated it. I just remember I had a vacation that wasn't a vacation because I was with him, not physically but mentally. Like talk about self-care. I wasn't using my time off for that because I never got a chance to really process it.

**Interviewer:** What do you feel would be helpful in supervision? What is the purpose?

**Informant 1:** That's a good question. I think that supervision would be helpful if I could really discuss cases and my emotions around it. I can let go of things once I have that moment and get some perspective. Like you just said a few minutes ago probably all I needed to hear. It's hard and yet we did what we had to do for that guy. It reminds you of what matters. I mean it would be nice for supervision to last more than 10 minutes. You know those little check-ins or whatever, time blows by and you're thinking to yourself like what just happened? I was going to share all these different things but time just got away. Supervision could be so much to so many of us, or at least to me, but I barely even know him. I don't know even know much about his professional history, and he definitely doesn't know about mine. How do you sit with someone who barely knows what you are even about and give them feedback or support? I think supervision should have professional development and like personal, not counseling or anything but I guess self-care and management. I mean without someone helping with my skills they won't grow.

**Interviewer:** How would you rate your skills at this point with the supervision you receive?

**Informant 1:** I think they have declined because no one has really paid attention to my work. I think that if I had supervision or just someone here to mentor me I would be able to discuss cases and really talk about my emotions so I could compartmentalize. Instead, it's one call after the other. I know it sounds dramatic and my partners would probably rag on me about it, but it's true. It's Groundhog's Day. I don't think I am a lost cause but I need support. For real, I need to get someone to support me so that I don't flounder. I may reach out to another supervisor just to get that need met. So, yeah, I know it is important.

**Interviewer:** We have talked about a lot of different things and some difficult things. I really want to thank you for sharing and giving your time to talk with me. You do such an important job and I am grateful there are people like you helping people in those critical moments.

**Informant 1:** Thanks.

**Interviewer:** Is there anything else you want to share? Or anything I didn't ask that you want to express here?

**Informant 1:** (smiles) No this was actually nice. I don't get this opportunity and it kind makes me want to get into gear and do something about my situation. I'm good.

**Interviewer:** Thanks again.

## **Informant 2 Transcription**

**Interviewer:** I appreciate your, um, willingness I guess is the word for sitting with me today. After reviewing the confidentiality piece of the interview you really seemed interested in other people's thoughts and feelings on this subject area. And already eager to perhaps join in the focus group?

**Informant 2:** Yeah, I mean I am kind of curious about some of the other people who are doing this and what they are saying. I get the confidentiality I just know this is an issue that is, like, um shared by many so I don't know. I don't know what I am saying, sorry about that. I will definitely be a part of that group. It's just nice to know there are people like you who get what it is that we do. Makes you feel like you have a crew, you know what I mean? So yeah, I'm all in for that.

**Interviewer:** Well I appreciate you sharing that. I'm glad you are open and interested. You will definitely have an opportunity to do that if you wish. We can kind of start at the beginning if that is ok with you?

**Informant 2:** Yep.

**Interviewer:** Ok, so let's start with maybe you sharing some of what your role as a crisis clinician. Talk a little about your work, if you don't mind.

**Informant 2:** Yeah, no I don't mind at all. It's the best job I have ever had. I meet the most interesting people every single day. I get to work with people from all walks of life. I go out on mobile crisis and we do what we can to stabilize people so they don't end up in the hospital or worse. But it's more than that. I get to see people after a huge disaster or event and give them a little hope, you know? It's a really cool job. I like, truly love it, and I never really thought that I would, you know? Love something so much. When I was

growing up my dad hated his job, it was just something that he had to do to support us but I actually like going to work, it's crazy. Sometimes, I can't believe I get to do this stuff. I love going to work every day. I never know what I will get to do. There is a ton of variety, which is right up my alley.

**Interviewer:** It's really great to listen to you talk so enthusiastically about your job. It's refreshing. You used the word "get" instead of "have to" and that just strikes me as someone who feels lucky, you know?

**Informant 2:** I feel lucky, I really do.

**Interviewer:** You talk about variety, which can be, um, it can be a really great thing. You know something different every day. For some, variety could be, I don't know, maybe stressful. Like not knowing what the day will bring or having to do so many different things can be tough, but you really seem to thrive off of it.

**Informant 2:** Hey, listen it's not for everyone. Change and variety is a constant at my job. A constant. You have to be flexible, you know? If you can't be then you won't survive. There is no black and white, right or wrong, it's just a lot of grey. I like that. I have never been a black or white guy, I always have seen things different. I like to think outside of the box, that's just who I am.

**Interviewer:** So your qualities sort of fit with this job.

**Informant 2:** Oh definitely. I didn't have to change much to do this work. It's in me. Like I had this one call where a guy, wait, is it ok if I share this?

**Interviewer:** Yeah, absolutely, absolutely.

**Informant 2:** I had this one call where we go and see this guy who called into crisis because his mom who was pretty old and had a lot of health problems was refusing to

take her medications that were pretty important. Like this was a crisis and the guy was panicked, you know? We get out there, my partner and I, and he is like a mess. He tells us, “I don’t know what to do she has to take these meds and I am the only one who cares for her and I just need someone to help.” She is mute, she stopped speaking like almost 3 years ago but she can hear and listen and I can’t convince her to take these stupid pills. So I like to think of myself as an “elderly whisperer” (laughs); I love old people and usually they really love me. I go inside and she is sitting there in her wheelchair just staring at us. I walk up to her and kneel in front of her, get on her level, and spits right in my face! I didn’t get to say anything yet. I was so mad. My partner walks over and says to the old lady, do these pills make you sick? I said remember she doesn’t talk. The old lady looked at me and said “I talk when I want to talk, I’m not a child and yes those pills make me really sick!” The son was like she hasn’t said a word in 3 years how could this be. The lady was like, “you never gave me a chance so I chose to be silent.” It was unbelievable. Unbelievable. We were there for like 3 hours, or at least it felt that way! The lady lost all her independence, and the son took over completely. I felt good about that call, like that may not have happened had we not gone there that day. We have other calls that were just so amazing. You know? Where we made a difference. Helped someone or did something that could not have been if we had not been there.

**Interviewer:** Wow, it seems like you really make a difference.

**Informant 2:** I think so. We had another call where I sat on the floor for 2 hours with a 8-year-old kid in a like a little cubby who was having a total breakdown, wanting to kill himself because he was getting bullied at school. Those moments are so cool. I mean the

kid refused to get out of that cubby and so I just stayed there with him and talked and talked and he came out and we figured it out, you know? It's nice to see success like that.

**Interviewer:** You're sharing some really great experiences. I'm wondering about some of the stories that didn't have the happiest endings that have some impact for you.

**Informant 2:** Oh, I have those stories. I have a bunch of those stories unfortunately. Things aren't always so perfect. I met this one guy who lived in a cardboard box in like one of those back alleys. Nice guy, little rough around the edges. The restaurant had called crisis because the guy was loitering and they felt bad calling the cops so they called us. He was a vet and had no family or friends, nothing. I mean the guy fights in wars for this country and we got him living on a street. Really not good. He of course was full of pride and wanted no help. I felt for him. I really did, I mean he was a vet and homeless; just didn't seem right. He would not let us help at all. I felt completely stuck like I could probably do a lot and this guy was so stubborn. I mean you see someone who you can help and all they have to do is let you but they can't. It's so frustrating! I tried to meet with my supervisor and some other people in the building to talk about ways to connect with this guy; no one was ever around to help. I started feeling like the guy, like I was on my own and had to figure this out. I knew winter was coming and was working against time. He died. I went to see him and he was dead. I mean I didn't know him. I only knew his first name and that may not even have been real. But no one deserves to die like that, not someone who gave up so much for others. That was bad. I felt bad for him and worse I felt like a total failure. I didn't like my job that day.

**Interviewer:** I'm sorry to hear that, it could not have been easy to deal with that plus feel like you were dealing with it alone.

**Informant 2:** Yeah, it was. I don't know, rough. I have had a lot of stuff like that happen in different ways but that was the first one and is still right here (puts his fist on his heart). I mean bad things happen, and I know that and I knew that when I took the job. It was a hard moment for me. He reminded me of my grandfather. I never told anyone that, not even my partner, but he did. Anyway. I did make an effort to find my supervisor and talk about it. She was like, "I get it," and I sat there thinking no you don't. How could she get it? She wasn't there. Don't we preach that we don't really "get" anything because we never walked in that person's shoes? That pissed me off. It showed how much she actually doesn't get me at all.

**Interviewer:** That had to be hard to hear. To, um, sit there and not get support for something so draining emotionally. What has been your overall experience of clinical supervision?

**Informant 2:** It's funny because I always think of that moment and how easy it could have been for her to give me supervision or counseling and how quickly she dismissed me. If she had done that and never helped me again I probably would be sharing a different story with you. I took that so personal. My experience of supervision is that I get it in some form; I touch base with someone but I am never satisfied.

**Interviewer:** Could you talk a little more about being "unsatisfied" when it comes to supervision?

**Informant 2:** I mean I get some form of supervision. I do. I just don't get what I need. I don't talk about cases or myself pretty much ever. It's like random if I get it and a case or



two but I have to bring it up. I never talk about my development or professional things like that. I never know where I stand in terms of my skill level. You know when things go bad on a call that is when I get supervision the most. Not bad like death, because that happens on a lot of the calls, but bad in terms of I missed something then a supervisor really wants to be a supervisor. You, know, protect themselves, which is pretty telling if you ask me. It's just annoying. It really is. It's annoying because when a supervisor stops you in the hallway or something and is like hey that case did you remember this or that and I feel like that is such a missed opportunity. Like take 25 minutes and sit with me. It could be so simple. I feel uncomfortable in my own skin sometimes on calls now. I feel like a fraud.

**Interviewer: A fraud?**

**Informant 2:** Yeah.

**Interviewer: Can you talk more about that word and what it means for you?**

**Informant 2:** I used to feel really confident, like I was good at what I was doing, but the last maybe 6 months, I feel like maybe I'm fooling myself and the consumer. Things change. Like what worked 10 years ago we know doesn't work anymore. If I am still doing the same things I was doing a long time ago, how could it still be right? I don't know if that makes sense, but it's just how I feel.

**Interviewer: Those are some strong words and feelings. What would be some of your expectations for a better supervision? What do you think is its purpose?**

**Informant 2:** I want to sit and meet with my supervisor. Supervision should be consistent and structured, not haphazard. I would like for my supervisor to know me, I mean that would be the first step. For them to know us the way we know each other. If

there was a relationship it might be easier, you know? One hour, uninterrupted by crisis, to sit and be heard. I'm game for whatever they want to talk about, but if I could just get some time to really talk I would be happy. I want to get better. I want someone to tell me if I am doing something wrong and when I am doing it right. I want to manage stuff. I want supervision to at least acknowledge that this job can take its toll on people.

Supervision to me at least would be my time. I don't want to feel like a crybaby that a call touched me in some way, I want to feel like I'm not alone and that this work is hard.

**Interviewer: You have a desire for that support. Are there times you feel isolated?**

**Informant 2:** I know my team has my back.

**Interviewer: I'm glad you have a team. You talked about, um, like skill level. How would you rate your skills on a scale from 1 to 10, 10 being amazing and 1 being not good at all.**

**Informant 2:** (laughs) Good counseling question! I would like to think I am an 8, but I think if I am being honest I would say I was at an 8 and maybe I am now like a 6. That is hard to say out loud. With all the stuff we have to see, knowing that maybe my skills are not being developed as should is really hard to swallow.

**Interviewer: That is hard. Thank you for feeling comfortable in sharing that. You say you're at a 6, why not a 4?**

**Informant 2:** I mean I'm not as low as a 4 because I think I have a good foundation. I still read a lot. I have a good team to check in with if I feel like I'm slipping.

**Interviewer: What do you think would help push you to an 8 or a 9?**

**Informant 2:** I mean, I think support, someone to bounce this stuff off of. Supervision would be a good push for me. I need to hear it, the good the bad and the ugly you know?

**Interviewer:** That makes sense. I really want to thank you for all you shared today.

**Informant 2:** I actually feel like I should thank you. It was nice to talk about this and talk about my work.

### **Informant 3 Transcription**

**Interviewer:** First, I just want to extend my sincerest thanks for agreeing to be with me and share your story. We can, um, if you are ready, we can just get started.

**Informant 3:** Yes, of course. I'm glad to do it.

**Interviewer:** Ok great. Thanks again. I think the best place for us to start is for you to talk a little about, I'm sorry, a little about your role of a crisis clinician.

**Informant 3:** Sure. Well my role of a crisis clinician is an interesting one that not many people have the opportunity to do, so I am lucky. I have been doing this work for, let me see, I have to think for a moment. I will be at my agency for 5 years at the end of the month. These days that is a long time to be one place. I really enjoy almost every day. I work with all kind of different people, mental health, no mental health, poor, rich, you name it and I have worked with them. All ethnicities and genders, some people that I didn't realize existed in our town. I provide support and stabilization in the form of crisis intervention. I see people in some interesting and difficult moments. I think the part of my job that is most unique for me is disaster response. I have the privilege of getting called into to some of the larger events in the area. The stuff that people might see on their local news, I am behind the scenes supporting the victims, helping the community.

**Interviewer:** It seems like after almost 5 years for you there is still, I don't know, energy around what you do. The larger scale disasters reignite some of your energy?

**Informant 3:** Yes. That is a good way to put it. I find myself reenergized when I get to participate in those. It is some meaningful work. I really believe in it, and feel so happy to be a part of all of this. I have cried with people and laughed with them. There have been so many moments I will take with me forever; they have shaped me in so many ways.

**Interviewer:** It's so nice to hear you so invested in your work and it seems fulfilling for you. I can see it in your face as you describe it. There have been many powerful moments.

**Informant 3:** I've made some imprint, several times along my way, and I am proud of that.

**Interviewer:** Would you mind talking about an experience that has been particularly impactful for you?

**Informant 3:** (laughs) Where to begin? There have been so many. Five years and thousands of stories, each had their own unique contribution to my repertoire.

**Interviewer:** I can only imagine!

**Informant 3:** You know, though, I remember a disaster that happened a few years ago that touched me. I am not sure what hits me the most about this one. There was a four-alarm fire in one of our boroughs and it was really devastating for the whole community, as you can imagine. Almost no survivors and the whole house was destroyed. Just losing the home is so hard to even fathom. Home is my safe haven, and to lose that comfort alone is almost unfathomable. Then to, to have to lose family on top of that is just. It's just so overwhelmingly sad. The worst was that one of the victims was a child. Innocence was lost. Just heartbreaking. I was there with a team and handing people water. I handed water to the mother who lost her child in this fire, and she actually remembered to thank me. I was so, so struck by that, she had manners in the worst moment of her life. I was standing over by one of the fire trucks and it really hit me that this was just one of the (pauses), one of the most powerful moments I've ever experienced. It is all so vivid to me, years later. I remember that night so clearly. I know it sounds ominous, but truly, I, if I

close my eyes I can picture everyone's face and the whole scene. I remember the smells and the tears of all those people as they helplessly watched everyone and everything that they love burn in front of them. I remember feeling sick and like that feeling you get when your heart is in your throat and you just keep swallowing, or gulping rather, so you don't lose it. Yeah, I remember that well.

**Interviewer: This is still so present in you.**

**Informant 3:** Oh my gosh, yes. I am tearing up just thinking about that loss. I don't remember specific words or phrases that I used that night. I really don't. I mean the water thing sounds so miniscule. I handed this woman water. She lost her whole family. I gave her water. It's all I had.

**Interviewer: Wow. That is powerful. Thank you for sharing that. Water, you know something that seems so simple, and yet it was meeting one of the basic needs that is the first step in crisis intervention, right?**

**Informant 3:** That's true and of course I know that, but that experience always stands out to me. I remember coming back from the event after my relief came in and in the parking lot my supervisor saying to me, "Go home and get some rest. We have a lot of work to do tomorrow." At the time I really believed that was a thoughtful statement, I still do. I think he was looking to meet my basic need in the only way he could. That event, in terms of us providing support, lasted for over a week. We did a week of continuous outreach and I will tell you at some point I really felt like I had a cut and kept digging at it every time I visited that site. It was extremely difficult, but I am proud of my part in it.

**Interviewer: So it continued to be a powerful experience for you.**

**Informant 3:** Definitely.

**Interviewer:** Thank you again for sharing that with me and thank you for the work you do.

**Informant 3:** Thanks for saying that. I really take a lot of pride in what we do.

**Interviewer:** That definitely comes through as we talk. Would you mind talking more about your overall experience of clinical supervision?

**Informant 3:** I get supervision if I absolutely need it. I am not sure how much I need at this point professionally. That's not to say I don't have new things to learn, but I dedicate time to my craft and to update myself as if I was in any other profession, so I am not sure that is his responsibility. I might sit in his office, which almost feels awkward because there is no real relationship other than maybe mutual respect. The space can feel a little odd, but we also don't talk about much. It's like those movies when the kids are in the last class of the year and it ends at like 3:30 and all we see is the clock ticking slowly and everyone waiting for that final tick so they can get out there. That awkward. We don't really discuss cases unless something goes terribly wrong. Every once in a blue moon he might check in and say something like, "things ok?" I take that as a check in on my self-care. For me I think it is an ethical obligation for supervisors to do this. I mean we are on the front line. I would like some space to talk about my emotions. The supervisors are busy and aren't getting supervision either; if I need something I will find a way to get it. The crisis event I shared earlier is a good example. That was a tough one, ultimately he trusted me enough to continue responding. I felt like I was not in a great emotional place, but I used my team to deal with it.

**Interviewer:** It would be helpful for you if they were more in tune with your emotions and emotional responses on cases? What do you see as the purpose of supervision?

**Informant 3:** I mean sure, that would be great. The purpose? The purpose is to help us help the consumers, the clients, to make sure we aren't letting our stuff get in the way. It can be frustrating to not get it, but I also don't let my frustration get much of me because I get it. There are a lot of us. One supervisor, you do the math. It can be hard and as a more senior professional, I get it.

**Interviewer:** It seems you have a really good understanding and awareness of the systemic issues that may plague your organization and probably many others in the field. What would be your expectations for clinical supervision?

**Informant 3:** I try. I have been around a while. That doesn't mean though that I don't wish it was different. I wish it was possible to receive it. Particularly for the younger, inexperienced crowd. It would give them an opportunity to discuss cases and determine skill level. For me, I would like some supervision for me to work out some of my own stuff so it doesn't spill on calls. I am human, and no matter how long I am in the field I still get impacted by some things. You know this thing, this supervision piece, it, it really should be a requirement we take seriously, but I know well enough that it isn't and at times it is almost impossible to actually implement. The organization needs it, you know. It is important for the whole structure. Who is supporting everyone else? I mean that is scary to think that the people who should be supporting me aren't getting supported either. It's a bad cycle.



**Interviewer: Thank you for your time and all that you shared. Is there anything else you would like to share with me?**

**Informant 3:** I guess I just want to make sure that I don't come across as blaming people for the lack of supervision. I want to be honest and tell you things aren't great and there is a lot of room for improvement, but no one person is to blame.

**Interviewer: Thank you. This study is totally confidential and really the purpose as we talked about at the beginning is to explore and learn more about the lived experience of supervision in crisis, which you have provided so nicely for me. Thank you again.**

#### **Informant 4 Transcription**

**Interviewer:** Can you talk about your role as a crisis clinician and your experience of clinical supervision?

**Informant 4:** Well, I love my job. I get to work with all kind of people, serious mental illness or not, and problem-solve with them. There is always something new and challenging. When it comes to supervision, hmm, well we have kind of a unique place for that. I think as a leadership team, I don't know, I feel like there are a lot of supervisors here. I had a supervisor when I started and it almost felt like an abusive relationship in some weird way. Like it was bad and I probably shouldn't have stayed, but it wasn't so bad that I couldn't manage, and I really love the work so the pros outweighed the cons. The leadership team here will send thank you's on certain cases in an email and that is nice. I mean to be recognized. The only thing is that when they send thank you's on some and not on others it can create some controversy. A lot of times one member of leadership doesn't know what the other members have said or done, which is frustrating. I feel like a lot of times I don't get what I need from my direct supervisor and I have sought feedback from my peers or other leadership in the building and they directed me back to my supervisor to explain that I wasn't getting what I needed. I did that recently and he was like, "yeah you're right and it's hard to give people the attention because there are so many of you and we are always busy." That was irritating because that isn't my problem, that's a system problem. The truth is why would he feel comfortable giving me feedback or helping me not emotionally respond to calls when he barely knows me? Supervision is a requirement, but like I am not sure I can really talk about the experience

because it's confusing. I mean there is administrative stuff but supervision is rare and it changes depending on the day.

**Interviewer: So you took the responsibility to get what you needed in terms of support and consultation from your supervisor?**

**Informant 4:** Yes, and now that I think about that it is kind of ridiculous. What is his responsibility, you know? I would ask him what I could work on and he would say, "nothing, you're good," and that just isn't helpful. I find myself trying to go to other members of leadership to seek the feedback and they seem hesitant because it crosses lines with my direct supervisor, it's strange.

**Interviewer: So what do you feel like is the purpose of clinical supervision here?**

**Informant 4:** Hmm, that's a good question. Do you mean for me?

**Interviewer: Let me rephrase it another way, you mentioned talking about asking your supervisor for feedback. What are some of your expectations for clinical supervision?**

**Informant 4:** Well, my first expectation is that it would happen weekly and it never has in all the years I have been here. Never. Honestly, I would like them to meet the need for supervision just in terms of that at this point. I'm someone who does better when I have someone checking in with me and hearing about my cases, good and bad. I couldn't tell you the last time that I had a serious 1-hour supervision in the crisis field. Maybe when I first started. Now it's rolling supervision; I mean what can honestly be addressed in 15 minutes? When things go wrong or if he catches me and needs administrative stuff. I go and get what I need, but I know I'm missing clinical and professional growth without supervision. Things don't get addressed and then they build up and I see it spill into my

work. Usually when it gets to that point I go to a peer or someone I trust in this building to help me work through this stuff. The problem with that is the peer is no more experienced than I am and sometimes tells me what I want to hear instead of what I need to hear.

**Interviewer: You are able to seek things for professional development at times with your peers, which can be a support for you, although you explained that isn't always reliable. What about your personal well-being, is there or should there be a component of that in supervision? What do you feel the purpose of it is?**

**Informant 4:** Umm, I think at times. It's only when something is really bad though. For example, I was out for a knee surgery. I had been in physical pain, and it was causing me emotional pain as well. I was frustrated and found that my patience was thin on crisis calls. I didn't get to share that because when I went to my supervisor and we talked about me needing some time to get my knee checked out his first question was, "ok, well how long are you gonna be out?" Not "are you ok" or "what can I do for you," that was pretty hurtful. I give a lot to this job, people could write a book on us first responders, and to know that his first thought was how many bodies will I need to fill the schedule pissed me off. I dread calling off or talking about anything like that because it has been such a letdown. I was out for 2 months and I got no response from my supervisor at all. Not a "hey, how are you" or anything. My team reached out and even when I came back he barely acknowledged me.

**Interviewer: That had to be difficult for you to experience. How is your knee by the way?**

**Informant 4:** My knee is all healed, thanks!

**Interviewer: It sounds like well-being isn't a top priority in your experience, would that be fair to say?**

**Informant 4:** Yeah, really fair. I mean well-being as a whole is discussed as this idea. Like the leadership team is always sending out random emails about self-care and staying healthy, but they do nothing to support it at all. It's program first. They send those emails like take time go to dinner with friends, decompress, but when you work for 15 hours and see the stuff we see it's hard. I have seen some things I wish I could forget. It's a joke that they send those emails and usually they fuel some anger in us. I feel like Cinderella. I can go to the ball when I get my chores done, the difference here is the chores are never done because you end up taking so much of the work of other people's lives home with you. We work 8-hour shifts and end being here for at least 10 several times a week.

**Interviewer: It can physically and emotionally exhaustive.**

**Informant 4:** It is. It's also the greatest job I have ever had. I mean I feel torn because I am ok staying here for 10 to 15 hours if that is what is needed. I guess it would be nice to get a pat on the back or have someone check in with me to really debrief after a call. We have shift supervisors who are like the air traffic controllers. They manage the building after hours. They manage what calls we take and are the buffer between us and our direct supervisor. The problem with that supervision is that there are three of them. They are all very different. You can tell what kind of support you will get depending on who is on and there seems to be minimal interaction between the shift supervisors and the direct supervisor anyway. There is never any follow-up; that is probably my biggest complaint. On Friday I work 9:00 to 5:30 and I know I won't leave this building until 9 p.m. because

Friday's are crazy. He never (my supervisor) even asks about all of the over shift and how drained I feel because of it, it's just the nature of the job.

**Interviewer: That must be challenging because in some ways in sounds like you are set up to fail before you walk in the door.**

**Informant 4:** Exactly.

**Interviewer: I'm hearing you talk about how "the system" preaches self-care and at the same time there is actually no self-care that can happen because of all these other tasks. It's almost like you are operating in crisis mode as clinicians.**

**Informant 4:** Yeah, and it's like you are last on that list. Everything and everyone comes before you. I expect that on a crisis call. When we see a family who just lost their child to an accident or a member of their family to suicide or homicide I put them first, but when I get back to the building it would be nice if my supervisor then put me first. I just had to hear everyone's worst nightmare and then go on my next call with someone who is in just as vulnerable of a position. It's too much at times. Even trainings and things that I really want to do get cut if there are crisis calls that supervisors feel are essential.

**Interviewer: It can be a lot to handle. The first responder role is always essential staff and you are talking about receiving very little to no support. Is it hard to disconnect?**

**Informant 4:** Yeah. When you said we are in crisis mode, it is true I am always in crisis. I don't know how to step out of that role. I was at a wedding last weekend and there was a guy there who was pacing back and forth down the aisle before the ceremony. I leaned over to the girl who was with him and I was like, "hey, what's your friend's name?" She told me and then I engaged him and we ended up spending the next 20 minutes outside

the church talking about him detoxing from alcohol. I felt like I had to step in because it could have turned into a huge scene, but seriously what is wrong with me that I can't be a normal attendee and go to someone's wedding without doing an intervention? It's like I am wired to never stop and I feel like that is reinforced at work. I can't turn it on and off and it takes over my life sometimes. We don't even get supervision in order to turn it off.

**Interviewer: You did a good thing by tuning into his needs and helping diffuse the situation, and yet it was your off day. So if you are constantly in crisis mode, how do you feel like that impacts your day-to-day work?**

**Informant 4:** It's hard to be fresh. I have a hard time taking each call as brand new because it feels like one long crisis call. It's groundhog's day. Which is kind of interesting because I always tell people one of the things I love about my job is that I come in and never know what my day is going to look like. At the same time it can be tiring. I find it hard to give people 100%. I haven't asked about it in supervision because I don't want him to think I can't do my job to be honest. There is a stigma attached to the crisis teams, we can handle all, and I feel like if he would ask me I would be honest, but if I bring it up it seems like I can't do it and that is not the case. Plus, it always seems like bigger things come up when I do get supervision. Documentation standards or a call that goes to media that we need to close up. It's rarely about me. I don't think I have ever been asked, "hey how are feeling, that call must have been tough" or "are you feeling burned out because I noticed you were over shift the last 2 weeks." Even if there is little he can do for me, it would be nice to be asked to know he knows and has some level of concern. We are on our own, many of us feel that way. It is why we have such a sense of camaraderie. We have each other's backs at the end of the day.

**Interviewer: The sense of team is very important to you.**

**Informant 4:** It really is. It keeps me sane. I just wish our supervisor or any supervisor knew how to be a part of that for us. I think it would be helpful if a supervisor at least noticed; “Hey you seem a little off or tired let’s talk for a few minutes.” We go on crazy calls and the only ones that ever get discussed are huge ones. Media or things that impact the larger community. I had a crisis call last month where an infant died and I had to sit in the room with the mother while she was holding her deceased child. I mean people don’t have to see that on a daily basis. No one ever said a word to me about that call. It just happened. No thank you, no “are you ok,” no “let’s talk about that case.” That is a lot to carry.

**Interviewer: What a difficult event for you to have to present at, have you been able to talk about it with your peers or do you still feel like you are carrying that?**

**Informant 4:** I talked with some of my team and feel like I am in a better place. I just wish it had been him or someone in the leadership role.

**Interviewer: We have talked a lot about your experience as a crisis worker and about your experience of supervision. Thank you for sharing some these personal and difficult things with me. I certainly appreciate what you do and the hours you give to this work. Reflecting on some of what we talked about and knowing what it has been like here for you, what would you do to improve the supervision you receive?**

**Informant 4:** I would first make it mandatory to actually sit down and meet. Sit in like, an office, not the hallway or the parking lot where we happen to run into one another. I mean that’s nuts. We need time for supervision. We could stagger people’s shifts so that



the first 45 minutes isn't crisis response but supervision time. I would like to bring cases to him, good and bad. I would like to have a moment to be genuine and say I am struggling. Supervision is so rare and holds a negative connotation that it would take a lot to shift how we view and how we receive it. I don't want to be seen as a flow chart. I have these symptoms and so it must be this diagnosis. I would like for people to acknowledge the lack of self-care and help me identify when it's an issue because ultimately I am in clinician mode and I can't see myself that way. I am an individual on this team, I have a certain skill set that I am not even sure he or any other supervisors know. How much of that is my responsibility and how much is his? I would be ok meeting with him with my team as well in a group, but we don't get that either.

**Interviewer: You are wondering if this is a shared responsibility. I also don't want to ignore you saying that you are an individual and not a flow chart. You do good work, hard work, and sometimes it goes unnoticed. I am also hearing you talk about team supervision or triadic supervision with a partner. Would that be beneficial?**

**Informant 4:** Yeah, I would really like that actually. It would help us debrief and process things instead of letting them build up. We could talk about cases and self-care stuff, I mean at least so people know.

**Interviewer: You talked about time to do it. How often are you receiving supervision?**

**Informant 4:** I haven't had supervision in 3 months. Prior to that, maybe monthly. I get it if I go and seek it out, not when he schedules it.

**Interviewer: Anything else that I didn't ask that you feel like is important to share regarding your experience with crisis work or clinical supervision?**

**Informant 4:** No. At this point it was actually nice to vent for a while. Thanks.

**Interviewer:** Thank you for participating and sharing your story. I will leave you my information so if there is anything additional you need please let me know. Also just to reiterate that everything we discussed here is confidential. I am the only one who will listen and transcribe this tape. Your name will not be used in any data appearing in this study. Thank you for your time.

### **Informant 5 Transcription**

**Interviewer:** Thanks for spending some time with me today. Ok, um, let's start with you talking a little to me about your, your role as a crisis clinician.

**Informant 5:** Well, I am a clinician here and have been for almost 5 years. I do whatever the situation requires I suppose. I work with people in whatever crisis they are experiencing, and, um, well my role changes depending on the need. I can be a listening ear, a provider of resources, a mediator, or a collaborator. It's a rewarding and exhausting job. I consider myself a counselor with the exception that the emotions I deal with are raw because they are still occurring while I meet with clients. It's, I don't know what word I am searching for, but it's an odd experience to be with people in these moments that are life changing. You have to bend yourself to fit whatever situation you walk into, you know? It requires you to adapt to whatever is happening and be ready to respond in an appropriate way. I'm not sure, does that answer your question?

**Interviewer:** Yes, thank you for sharing that. It sounds like something you, at least from the tone and the way you were describing your role that it is one you enjoy, would be that be correct?

**Informant 5:** It is, definitely is. I know when I go into work that day I am needed.

**Interviewer:** Being needed is important, you feel valued.

**Informant 5:** Valued is the right word. I am valued and that is a good thing and can be rare for many people. I have held other jobs in the field and have been around, this is the only one where I have felt that way and that satisfied.

**Interviewer:** That is refreshing to hear. I'm so glad you are in a position where you know your work matters. Would you mind sharing your experience of clinical supervision in crisis work?

**Informant 5:** Of course. You know supervision is a rare commodity. I get it, in quick spurts, you know check-ins. I mean I'm not sure if that is actual supervision I suppose. I mean I know what clinical supervision is, I was a supervisor, a clinical supervisor for many years before coming to crisis. I know how hard it can be, you know to spend time with staff and really dig into supervision. Everyone is so busy, including them, that really doesn't, it just doesn't allow for time for supervision across the board.

**Interviewer:** So you have some experience on the other side of knowing, perhaps the challenges of implementing supervision.

**Informant 5:** Yes. It's tough to do. I mean reviewing cases and such. It's a tall order when the system is set up to just go go go, you know?

**Interviewer:** When was the last time you sat with a supervisor?

**Informant 5:** Hmm, well actually the last time I sat with my supervisor was when I had to go over my review. We have reviews, you know, yearly, to make sure we are keeping up with all the requirements of the job. I had my review 2 months ago. We sat down and went over the past year and skills that I have done well with and things I need improvement on. During that supervision I did, um, I did use that opportunity to discuss a case with her that was bothering me. She gave me some tips then, so that was helpful. Mostly I think I go to her if I would really need something. I mean if things were really bad then maybe I would need more supervision. I know as a supervisor myself that I tend

to pay more attention to the ones who need help, so the fact that I am not getting as much attention is a sign that I am ok. Am I making sense?

**Interviewer:** You met with your supervisor at your review to discuss the skills that you have displayed over the past year and you used it as an opportunity to discuss a case, which was helpful.

**Informant 5:** Yes, exactly.

**Interviewer:** Also you mentioned that just in your experience you feel like maybe you need less supervision since people aren't paying as close attention?

**Informant 5:** Right. I mean not, not in the sense that I am so good I never need help, but that for the most part I'm ok. I can figure stuff out.

**Interviewer:** You feel like you are able to get by, and if you really need something you would ask.

**Informant 5:** Yes. And you know crisis is set up in teams. So you are never alone in that sense. Like if I needed something the best people to go to would be my partners anyway because they know me and my work much better than any supervisor anyway. We are a close group. I mean we see some really difficult things together so we are bonded by that if nothing else. I have been on many different calls that pushed buttons for me and I have used my partners to debrief and make sure I was ok so that I could go to the next one. I am grateful for that you know? It's like we were all meant to be together and do this kind of work, 'cause it isn't for everyone. It really isn't.

**Interviewer:** Peer supervision has been helpful?

**Informant 5:** Definitely. I know how busy the supervisors are. I get it. I mean the system is not set up to support itself at all. That isn't a judgment, that is just a fact. I mean the supervisors aren't getting supervision either.

**Interviewer:** From what you are saying it sounds like it's more of a system issue.

**Informant 5:** Yes! That is the thing everyone is getting let down so hopefully the people who are struggling get what they need and everyone else finds a way to support themselves.

**Interviewer:** If you could get it. Like regular supervision, what would be, what would your expectations be for it? What would supervision look like?

**Informant 5:** Wow, that's a tough question. I mean I think crisis work is so hard to supervise because there are so many components. I guess ultimately supervision should include team supervision, case reviews, and probably some self-care stuff. I mean we see so many people, so many patients a day, that the supervisor has no idea of all the people we come in contact with on a daily basis let alone a weekly one.

**Interviewer:** So case reviews would be helpful for you and the supervisor. What about team supervision and self-care?

**Informant 5:** Well we are a crew of workers. Hard workers. We stay late come and in early, go from call to call. The calls aren't easy and sometimes it might be nice for supervisors to check in and make sure we are ok. I mean we are the direct care. We are out in the community seeing people. Unlike other counselors we work in pairs constantly. Team supervision might improve our abilities to work together. There are definite style issues that might work out differently if there was someone to intervene.

**Interviewer:** So all in all there are a couple of areas of supervision that would be beneficial in your line of work?

**Informant 5:** For sure.

**Interviewer:** Well I really appreciate your time and your experience. Is there anything else that you need from me?

**Informant 5:** No. I think I am good. Thanks for doing this.

## **Informant 6 Transcription**

**Interviewer:** Hi and thanks so much for meeting with me to discuss crisis work and supervision. Let's start with, um. I'm sorry I'm trying to get all my stuff together here. Can you talk a little about your role as a crisis clinician? What all that entails?

**Informant 6:** Yeah. My role is to go out and assess the situation to determine what each individual in crisis may need. I mean we go into the environment, you know what I mean? So whether that be the school or the home or the alleyway, don't matter, we go and do what we need to do. We might be facilitating hospitalization or linking to resources or someone to talk to, it really depends, you know? All the situations are so different. We wear a lot of different hats depending on the situation. We do disaster response, and it's like basic needs, what can we do to make sure we can get you to the next moment, we do small-scale crisis so that could be anything and maybe we formulate more of, uh, more of like a plan. You know, maybe that is more long term. It's fun. I never knew jobs like this existed. I am important and help people who can't see solutions . . . that is why I went into this field, to help and make a difference. I do that, that's something I can be proud of, so yeah, that is what I do.

**Interviewer:** Wow, ok. Thank you for that description, that's helpful. So it's busy and constantly changing and yet you're still here doing and loving it.

**Informant 6:** Yeah, absolutely. The need to help, the want to help, that's in me. I can't shake that part of me.

**Interviewer:** It sounds like you feel as though you belong here and you seem to enjoy it.



**Informant 6:** Yep. There isn't one day that is the same here, no two days look alike. It's that variety and excitement that make it fun and challenging. I mean when people leave here we almost always hear back from them how bored they are at their new job and many of them try to come back. I mean that says something. We have very little turnover here. I mean I'm no administrator; I don't know the numbers, but people don't leave here, if they do it's to, um, to move up or around in the system. Don't get me wrong, there are days you walk out dead tired. Your body feels it because your emotions go through the wringer. But most days you walk out proud. I am a part of something so much bigger.

**Interviewer:** You paint such an inspiring picture. I can hear the passion in your voice. It seems like this is the place to be.

**Informant 6:** (laughs) Well, if you're like me, then yeah, for sure. For sure. But you know it isn't for everyone. Some people like that sit-down monotonous therapy life. And you know we work shift work which is really tough on you emotionally and physically. We don't have a lot of support aside from each other because no one gets it, but it's a lifestyle. You know that should say something right there. All the research says something like shift work is so bad for you and impacts all these areas of your life in a negative way and here we all are working shifts in crisis no doubt. Which is more than shift work. I mean we work late almost every day. It's not like I can leave at 5 'cause my shift is done . . . if I'm on a crisis, and the crisis is still going, then so am I. You give up something working in this. Your whole family gives up something. It's a commitment, but it's like addicting. We want to be here and we keep coming back. I worked 'til 3 a.m. on Monday and came in for a 10 a.m. shift the next morning. I got a few hours of sleep and was back at it. A lot of us do that. And I think that speaks volumes. I mean it's not

the healthiest. I don't know if like all the bosses know we do that, but it's real. It happens all the time. Someone has to be there.

**Interviewer: It sounds like it's important to stay at your best given the intensity and variety of situations you have to deal with on any given day.**

**Informant 6:** Definitely.

**Interviewer: So how do you stay at your best?**

**Informant 6:** Self-check. Constantly. I mean I lean on my team. I love my team. (laughs) Well I like love hate my team. We are tight but together a lot. So you know, dysfunctional family sometimes. I mean calls can pull on my buttons you know? I mean I have a little kid and kid calls can be rough. You hate to see someone suffering or a parent doing something stupid and dangerous. I gotta constantly watch myself for getting sad, angry, frustrated, anxious because that can ruin a call and impact safety too. We go call to call so the call I got at 8 a.m. is still with me at 2 p.m. and I have to be together and so does my partner. That's why team is everything.

**Interviewer: I can see that. So partnering is crucial and self-awareness is necessary at all times. How are you able to do that?**

**Informant 6:** (laughter) Well, sometimes I'm not. I mean I am not superhuman. I have to watch my red buttons, you know those situations that might hit me different and make sure my partner knows.

**Interviewer: So you deal with it and then when you are done with the day what do you do with all those emotions that came up during the day?**

**Informant 6:** Swallow them. I got a kid and a life that I have to be present for and there is no time for work to get in the way. I don't always succeed at that. Actually I fail a lot. It's a little annoying. I do the best I can though.

**Interviewer:** It can't be easy to feel like you can't succeed with something that you consider so important.

**Informant 6:** Yeah, it's tough. I mean I have my team and they get it so we work through some of that.

**Interviewer:** What about supervision? Can you tell me about your experience of supervision?

**Informant 6:** Hmm supervision. Well supervision here is sort of in the moment. I mean I sit with my supervisor maybe once every other month. Depends on the day. We are always on the go so it feels like its 10 minutes here or 5 minutes there. Everything is constantly in motion so sit down supervision is hard to come by. I mean when things go really bad, someone gets hurt or something might end up in media, we sit down with the supervisor. Every once in a while if I have a case that is really driving me crazy I may try to schedule some time with him. My problem is they are always busy, too. It's like everyone here has so much to do so it's hard to take a minute and really focus on much of anything. You know? I mean I like my supervisor just fine but it is kind of crazy 'cause those are the guys that evaluate you for like salary increase and stuff and they probably know really little about me. That's crazy to think about. But I guess I'm doing alright if I haven't been pulled in or anything. Like I guess I know what I am doing for the most part because otherwise they would tell me.

**Interviewer: So supervision has been sparse but you take it as you are doing ok since you haven't been pulled in?**

**Informant 6:** Yeah, I mean I would assume if things were bad we would know about it. Supervision is important but I also know that I count on my team for the things I would want in supervision. Cases and checking in with people, you know? I mean my team, you know, they know me. They see me. My supervisor doesn't really know that much about me. So you know on like a first date you have to get to know people, they need to sit and have that first date to get to know us and we haven't really had that. It would be nice, don't get me wrong. It would be nice to have someone be like, "Hey you ok? Everything ok?" or "How was that call?" I don't know.

**Interviewer: So case reviews and self-care is important? Would you want supervision to include those things?**

**Informant 6:** Yeah, I mean supervision would be helpful if I had someone to like debrief with. We deal with some hard stuff. We talk to each other but it would be nice to have the outside perspective to make sure my check-ins are working, you know? I had this one case where the mother smothered her baby. I had just had my son, and here I was trying to talk with a woman who had done this to her child. It broke my heart and angered me to a level I can't even tell you. I remember trying to stay silent for most of it and let my partner handle the majority of the call. I was disgusted. I could have used supervision then. To just talk and deal with it. There are a lot of calls like that where it would be nice to have some space to really talk and deal with some of those emotions. I mean I can't be judging people. I need to respect the situation and the people regardless of my own values. I mean she was a young mom and was totally unprepared. But you know, me, um having

my own baby right around that time, it was a trigger. I can't even remember the calls we handled after that, which is kind of scary.

**Interviewer:** So given some of the difficult things you have had to face, supervision may be helpful to really support you and help enhance your skills.

**Informant 6:** Yeah, I mean that would be nice. Some face time. You know those check-ins or whatever we do to touch base it's just, it's not enough. The supervisor grabs you in the hall or something and wants to do this quickie supervision so you feel kind of cornered and you can't think of the million things you know you want help with in that moment. We do the best we can though. I can speak for my whole team. We all try and our hearts are in the right place.

**Interviewer:** I can tell. Thank you so much for your time. Is there anything else you want to share?

**Informant 6:** I don't think. Yeah, I'm good. Thanks.

## **Focus Group Transcription**

**Interviewer:** First, I really just want to, um, I just want to say thank you so much for all your help and assistance in the interviews. I learned so much from each of you and I'm looking forward to sharing with you guys what I found. I listened to the tapes several times through. Once for transcription, the second time for tone and some key themes, and a third time for some words or phrases that were continuously used throughout all the interviews. Although you each shared a pretty, well actually, a, um, a very unique experience, there were some common themes that were threaded throughout the interviews. I wrote down the themes here (shows paper) and, along with some description of that theme, and was hoping that I could be more of an observer in this process. I may ask a few questions here and there but would like to let you guys discuss the themes and your experience of them. What they mean to you. Whether you agree or disagree and how it fits or doesn't with you. I'm sort of hoping for this to be a discussion of the themes and what they mean to you. There are no names beside the themes so it's still confidential, so, um, whatever you decide to share is up to you guys. I will be listening and can clarify something if it isn't clear. Would anyone like to volunteer reading this first one to get us started? Each of you have a copy so you could take turns reading each theme out loud and then spend a few minutes discussing it.

**Informant 5:** I'll start, or I don't actually mind reading them all off.

**Interviewer:** Ok great. I appreciate that. So I will hand it over and it would be good if you can read the theme and then discuss it with one another. Whether that, like fits with you, or, you know how you make sense of that theme in your experience.

**Informant 5:** Yep, I can handle reading this one to you all.

**Interviewer:** Great, thanks. I will, I am going to be here and writing some notes that you guys are welcome to look at it, if you can read my handwriting, which is unlikely. But I may ask a few questions just to get some clarification from you guys but mostly want to kind of leave you guys to it.

**Informant 5:** Ok. Let's see, now do I just go in order?

**Interviewer:** Yeah, that's good. Just go in order. I mean they are in no specific order as far as ranking. They are kind of random based on the notes I took from your individual interviews.

**Informant 5:** Got it. Ok, um, the first thing on the list says collective sense of pride and passion for crisis work. Do I have to read the stuff underneath?

**Interviewer:** You can. Everyone else has a copy so those are some clarifiers to the theme. Whatever works for you guys to generate the conversation would be fine.

**Informant 1:** Well, I can.

**Informant 5:** I can talk, oh sorry. You can go first.

**Informant 1:** No I was just going to say that is an easy one to talk about for me. I am really proud of the work I do. I love the job and the work is always something new. So yeah.

**Informant 5:** Yeah, I was going to agree. I, um, I really love the work and feel excited talking about it usually. People at my agency always refer to us as the "cocky group" and I take that as a compliment because we are confident in what we do and we are good at it. I don't know how everyone else feels.

**Informant 3:** For me I mean I agree with both of you. At our place people think our teams are “tough” but you know we have to be because we are there in dangerous situations and we are tough but good. I mean we keep coming back, I keep coming back so. Yeah, passion and pride make a lot of sense.

**Informant 2:** Agreed.

**Informant 1:** Alright then, we agree. We are awesome. (laughter) The next one says value in the work that is done on a daily basis. I mean I feel like that is what we were just talking about.

**Informant 5:** Yeah. I mean I am passionate because I know the work I do matters.

**Informant 6:** I mean I can see how that theme is a little different. I could love my job but my job might mean nothing in the big picture. I took this one as I was made for this job and it matters to people. I agree, I mean I feel like this is where I belong doing this work with the people. Sometimes I wonder what people did before crisis teams were an option. (laughter) You know?

**Informant 5:** I don’t know about fate, but I do know that the work I do is important. Like I don’t work in retail where no one remembers me being there.

**Informant 4:** I mean I think all jobs have value. I’m not sure how comparable it is but it’s hard for me to picture doing anything else. I think I would be bored. I know when I’m on it is crucial for whoever I meet that day, so, um, yeah, in that respect people need me.

**Informant 6:** If it wasn’t you doing it would it be somebody else?

**Informant 4:** Are you asking me that?

**Informant 6:** Yeah, well, no I mean I am just asking the group. I mean that is how I take this. I was meant for this and no one else can do it like me.



**Informant 1:** (laughs) Well I'm confident I am good at what I do but I'm sure other people, like, could do the work if it's in their blood, too.

**Informant 3:** I think that our work is really important, and I think my skills that I naturally have fit with the field. So. Yeah.

**Informant 5:** Does someone else want to read?

**Informant 3:** Yeah, um, let me look. The next one says strong sense of team and partnership/bonding among clinicians. I mean I think this one is definitely true. I have friends who are like you are way too involved with people at work, but like, I see it as invested.

**Informant 6:** I get what you're saying though because I see my team more than I see my family on most days.

**Informant 5:** So true.

**Informant 4:** Team is everything. Without my partners I don't know if I could actually do the work.

**Interviewer:** What is it about the sense of "team" that helps you do the work?

**Informant 4:** I mean they keep me sane. They help me make sure, I'm like on the right track. They know my work and my mood, you know?

**Interviewer:** What about for the rest of you?

**Informant 1:** It's funny because some of my partners drive me nuts and at the end of the day I know they are the only ones who get what my day has been like. When I go home at the end of the day and my boyfriend will be like oh I had a long day I have to hold back a "really?!" You don't know what long is!

**Informant 3:** Yes! Preach! My girlfriend is the same way.

**Informant 2:** I feel like for me I mean with confidentiality and everything it's important that I have my team to debrief. I mean when you want to cry or punch something after a call that really struck a chord, your partner gets it. And they care.

**Informant 5:** Team is what makes the ship run. Is everyone good to move on, I feel like we all agree on that one, um, ok. So the next one.

**Informant 1:** We kind of already formed a team here! (laughter) I mean that bond is so important. Sorry to interrupt. Go ahead let's read the next one.

**Informant 5:** Yeah, you're right. Ok, so the next one says a job that requires constant flexibility. Ha, that is the understatement of the year for me. I mean flexibility is the name of the game. Flexibility on crisis calls, flexibility in supervision, flexibility in partnering, man, it is everywhere!

**Informant 2:** That is true. I mean if you are a concrete thinker and that is the environment you thrive in, you can't, I mean you like can't do this work. How many times do we have something for after work and there is a call. Or how many times are we supposed to meet or whatever but we have to switch gears and do something else. One time I came into work, this is a true story, solely because I was coming in for an interview for a promotion or whatever and there was this huge crisis on the county line and I'm all dressed up, suit tie and the whole deal, and they were like can you help? I mean of course I can help but it's like nothing is a priority but the crisis calls. Everything else is on the back burner. It's a little frustrating honestly, because you can lose your identity. You have to be a chameleon and change with the setting.

**Informant 3:** Man I hear you. That happens to me more than it doesn't. I piss so many people off by not being able to be there on time for something or missing something completely. I don't just have to be flexible, everyone involved with me has to be flexible.

**Informant 6:** You know it's kind of interesting to, because like, um, you have to be flexible for your own safety, too. You know call to call needs something different. We are this for this person and that for that person. It's a lot.

**Informant 5:** Which sort of leads into the next theme of emotionally and physically exhausting crisis calls or events. It's tiring to have to be like so many different things to different people.

**Informant 6:** If someone asked me I could probably describe in detail several crisis calls that are still with me.

**Informant 2:** Me, too, for sure.

**Informant 1:** Oh yeah, I mean I can recall most calls, but definitely ones that were emotionally trying I can tell you everything. That's the thing with the teamwork that is so important. I need some space and someone to talk to about that so it doesn't hurt another call, that is like a big fear I have.

**Informant 3:** I hear you loud and clear. I mean to be able to really talk about those calls with a supervisor would be so helpful, even a couple of minutes. It's like I have nowhere to put it until I talk it out and so I have to hold on to it. You know?

**Informant 5:** I definitely agree. Also though I think that is part of the job. I mean we knew when we signed on what it entailed. I think that is why we are in teams, since supervision isn't happening at least we have our partners.

**Interviewer:** Just something for you guys to consider, what happens when you and your partner face a difficult circumstance together?

**Informant 2:** Well not every traumatic event is traumatic though. I guess if it was then use someone else on the team, or go to the bar! (laughs) I'm just kidding, I don't have a problem or anything I just know I have to have an outlet.

**Informant 3:** Yeah, I mean I don't want to traumatize someone else by sharing it with them but our team, they have seen stuff. So it's kind of all I have.

**Informant 5:** Again though, I think that I could pull the supervisor if it was so bad but it might take more time to explain the situation, which wouldn't be productive.

**Informant 4:** Right. I mean you suck it up right? We could talk to a supervisor if we absolutely had to but things are constantly moving, too. I have felt sick to my stomach after some calls. Sleepless nights, the whole nine. Like what people don't get is that there isn't a time. We are always busy. Everyone is.

**Informant 1:** Yeah, I don't even know what that would look like.

**Informant 6:** Well, it seems that the next theme is right in line, too. It says always in crisis mode and struggling to disconnect from work. I know that is true for me. Or so I hear from everyone in my life!

**Informant 2:** Exactly, other people love to point this out. It's hard because I definitely replay some things in my mind.

**Informant 5:** There are days I would like to forget but it is a challenge. The work is intense. Fun, but intense.

**Informant 3:** I feel like I have built so much inner strength in this job that I didn't know I had, so like in that respect it's good. At the same time it can make me jaded, too.

**Informant 4:** I totally agree with being jaded. I have a morbid sense of humor as it is. I get told all the time that I can be harsh by my family. But like if you don't develop a thick skin you can't survive.

**Informant 6:** I think the thick skin is necessary, it would also be nice every once in a while to be human.

**Informant 5:** I consider myself pretty human, but for sure on calls to remain professionalism I can hold it together.

**Informant 1:** Isn't it crazy how professionalism means holding it together?! I mean that is nuts. Like for real, that shouldn't be the case. I mean no self-disclosure and I mean of course you can't make the call about you and your emotions but, damn, we have emotions. How could you not when you see someone die, or you watch people suffer?

**Informant 5:** No, I'm not . . .

**Informant 6:** I don't think, sorry (looks to informant 5), but I don't think we should stop feeling, it's just there is a time and a place for it and I think we can all agree it isn't on a call, right? I mean . . .

**Informant 1:** Of course not on a call, but then when?

**Informant 2:** Yeah, I mean that is a good point, when is a good time? Sometimes it seems like there will never be a moment. I mean my supervisor is running and doing their thing and I am sitting here collecting baggage. It's, it gets . . .

**Informant 4:** Heavy. It gets heavy. I hear you. I mean that is where supervision really fails us but our team helps.

**Interviewer:** This is great conversation. I'm hearing the struggle to detach, how do you guys know when you have officially disconnected?

**Informant 6:** I need someone to tell me. I try to keep track myself but ultimately people have said I can tell you're back now.

**Informant 1:** That is an area that I desperately need supervision for . . . because I don't know. And I think most of us would be lying if we said we are always self-aware, I mean nobody, like, is constantly self-aware.

**Informant 5:** I think I have a good amount of self-awareness. I know I have disconnected when my muscles can breathe and I am thinking about something other than safety or death or danger. I have those moments and I try to tune into them for my own sanity. I don't think we should need people to point that out for us.

**Informant 1:** Not all the time but seriously. I mean seriously, you can't do that all the time. Like where is the barometer?

**Informant 3:** I feel disconnected when I can sleep without waking up, which is rare. I mean I don't have the healthiest sleep patterns but when I feel somewhat rested I know my mind isn't going over cases and stuff. Like my conscience is clear.

**Informant 2:** I don't know if I could sit here and say with certainty that I have ever been fully disconnected.

**Informant 5:** There has to have been some moment when you have felt that way? I mean what is disconnected to you?

**Informant 2:** I guess it would mean not thinking about anything work related at all. Enjoying the moment. My mind is always somewhere else. Even right now I am thinking of work.

**Informant 6:** Well, yeah, we are talking about work.

**Informant 2:** I'm just saying . . .

**Informant 5:** I think supervision or not you must have had moments. Maybe it's hard to think of them on the spot.

**Informant 3:** I get what you are saying though, like, I mean if we are constantly going going going it can be hard to remember the moments where we stand still for a few seconds.

**Interviewer:** I wonder how this all fits with the next theme that was prominent of countertransference.

**Informant 1:** I want more than anything truly to say nothing of mine has spilled onto calls but I know that is not true. I mean I'm not talking about anything bad, or like extreme, but there are definitely times where I am pissed off and probably shouldn't be or times when I tune out.

**Informant 2:** Those are natural, don't you think?

**Informant 5:** Yeah, I think that is different than countertransference where it negatively impacts the call or the consumer, you know? I mean no one is perfect.

**Informant 6:** Yeah, I agree. I mean, I took this as things spilling into calls that impact them. I don't think I do that. I mean I have been doing this for a while and would think it would be pointed out to me you know?

**Informant 5:** I am sure there are moments, but nothing, too, uh, what's the word, detrimental. I feel like my partner would have called it out or my supervisor would have grabbed me to make me aware of something, so it, it a probably wasn't anything too intense.

**Informant 3:** Yeah, but how would the supervisor know if you don't see them? I mean the countertransference is scary for me because the thing is the only way a supervisor

would know would be to check in with me and listen to a tape or be with me on a call and none of that happens.

**Informant 5:** Well, yeah, but the thing is that is why we have partners. To help us see what we can't and then if there is a problem it can be addressed in supervision.

**Informant 1:** The thing is that is a lot of pressure on the partners. I mean I am not constantly monitoring my partners. I have to monitor myself and attend to the situation, like why is that my responsibility?

**Informant 2:** I agree. I think that is a lot to ask of a peer. I mean I don't get paid supervisor salary, that's for damn sure (laughter), so like why should I be watching other people that way? I mean I am a team player and I will help when I can, but how good is my vision if I am totally burned out myself? I mean that is crazy if that is the assumption.

**Informant 5:** Whoa, well I don't see it that way I guess. I am a senior clinician and have been around a while. If I can give feedback then I do. Why wouldn't I?

**Informant 4:** It isn't so much that I would or that you wouldn't I think what is being said is kind of valid though. Like seriously I am already focused on the crisis and all the players in that plus myself and now I'm watching my partner? It's more than not my job it's not safe. For any of us.

**Informant 6:** I can sort of, I don't know, see both sides, but my thing is I already feel like I do everything and now that is like one more, um, one more like task on my list. You know what I'm saying? I mean I am all for jumping in and helping out but like if we add something else on the list then something else has to come off, like, it's too much.



**Informant 1:** Yeah, I agree I mean we talk about flexibility and wearing all these hats but there has to be a limit. I mean the point of supervision is someone who is trained and outside of the situation who can provide like, I don't know guidance of some sort. Right?

**Informant 5:** Yes, at the same time I think what I was talking about was peer supervision.

**Informant 2:** I will be honest. I think countertransference can happen to both of us on a crisis call and if that is the case then we're both screwed because no one is aware enough to make a judgment. That has to happen in supervision and it doesn't.

**Informant 3:** I agree. I mean the thing is that we need something additional. Someone who can hear the work and the personal and help us figure stuff out. It's like we can't move forward without that.

**Informant 5:** I mean, supervision, supervision in general would be good. I don't want to say or I guess I don't mean to say it isn't needed at all, I'm just saying we can have, we can do some things on our own. Ultimately I mean it would be ideal for supervision to happen, but that just isn't likely because it's almost impossible to do in the system. You know?

**Informant 6:** I think that's true but . . .

**Informant 1:** But, sorry, but that is not our problem.

**Interviewer:** While the topic has drifted toward supervision why don't we look at the next theme, supervision occurring in the moment and not a sit down debriefing.

**Informant 2:** This is so true. I don't remember if I shared this or not, in my interview, but like seriously they call supervision any contact with my supervisor, no seriously that is how she defined that, like I can't even, she told me that was the case. It's kind of a joke.

I once complained to an old supervisor I had that I never got supervision and she was like “you’re problem is you don’t know what supervision is ‘cause you get it all the time.

Those moments when you ask me something about a case or the 5 minutes we spend in the hall that is supervision.” She actually had me thinking that I was stupid for like, a minute, like maybe my expectations are too high or something. I can’t believe that but it makes me realize she doesn’t know what it is either! Ha, you know like if she doesn’t know how the hell am I going to know?!

**Informant 1:** I heard something similar from my leadership team. Like supervision happens and you have to soak it up. Like have I missed it? Isn’t supposed to be a sit down conversation. I don’t get it.

**Informant 6:** Yeah, I mean I think that supervision happens that way because there is no time. Like I think, I really believe that the supervisors want to do it they just, they can’t.

**Informant 5:** They’re tied up so, you know. Like with their own stuff. Totally tied up and asked to do a million things. That is why I try to take responsibility because I know it’s not physically possible for them to do the sit down debriefing. I think supervision can happen in a few minutes if you are open to receiving it that way and depending on the level of your skill, like . . .

**Informant 1:** There is no way . . .

**Informant 5:** Wait, let me finish. So I have been in the field for a while and may need less than someone who is brand new. I mean everyone in here has more than what 2 years or something? Of experience? So you are established somewhat.

**Informant 2:** Yeah, but so then you are saying supervision is for people who suck at their job.

**Informant 5:** I wouldn't use those words at all, but maybe, I don't know, maybe like people who are still building their skills need the extra support, whereas, you know, if you have a solid skill set you need less.

**Informant 3:** I think, I mean I can't obviously speak for everyone but I definitely don't agree with that. I think supervision should be for everyone.

**Informant 2:** Yeah, on some level actually, should supervision be more for the people who are good, so they can like stay good? And maybe you build those clinicians to help lead others? Like that doesn't make sense, why spend time with the people who are failing?

**Informant 4:** I can see both sides. I mean think about teaching. If you do what you are supposed to and turn in your stuff the teacher doesn't keep you after class. They keep the students who are struggling.

**Informant 1:** Yeah, but why not be proactive? I don't like that theory at all of supervision.

**Interviewer:** Let me interject for, um, for just one moment. This is great conversation and debate over supervision and its purpose, you know? This discussion leads to the next two themes of what the lack of supervision means. So let me first start, whoa, hang on, dropped my paper, let me first say that one theme was the lack of supervision can lead people to question their skills and development and another theme was the opposite leaning towards the lack of supervision being a sign that maybe supervision isn't needed that much for that person. Would you all mind talking about your interpretation of those themes and the meaning for each of you?

**Informant 2:** I will go first on this one because this is something that I feel pretty strongly about actually. I, um, I sometimes feel like I am not as good as I was because of the lack of supervision I've received. And you know, maybe some of that is on me. I am not sitting here complaining that it's all someone else's fault, but like I have been in counseling. I have a master's, I'm not a complete idiot. I know that supervision is required and ethical to enhance skills. So like, it's actually a function of their job. Like my function is to assess and stabilize crisis, you know? So the fact that we are not, um, sorry, the fact that we're not having supervision isn't 'cause we don't need it. We all need it, I don't care how long you've been around. It's impacting our growth. I mean as you age you don't stop needing your parents, you like, you know, need them differently than you did, but you still have a need for them to teach you stuff or whatever. I don't if I am making sense.

**Informant 1:** I agree with 100%. I don't get supervision and there are times I think, well, maybe I'm doing alright, but then I will notice something or even hear stuff from my partners and get feedback. Like where the hell is the supervisor? That is their job.

**Informant 5:** I'm not saying you never grow or learn. I'm just saying you find other ways to fulfill that need. The thing is that most of the supervisors don't really even know us to do the work, you know, the work of supervision anyway. We know each other in a way they can't.

**Informant 2:** Yeah, but that's a problem. A big problem. They should know us, our work, and our clients!

**Informant 4:** I mean I agree with what you both said (pointing to Informant 1 and 2) and the thing is the meaning for me is that I am not worth the time. Like other things are more important than me, and that sucks to feel that.

**Informant 2:** Yeah, I hear that. The meaning for me is the same, like let's get this straight. You guys want me to put the consumer first, like always, finish my paperwork within 24 hours, do all these other things, and you can't put me on your list? Like why should I do this for you? I mean, like I do it. I do it because I want to and because I like this job and this field, but that is shady.

**Informant 3:** I think for me the meaning is that my emotional well-being is really not that important and my professional well-being is only as important as long as it doesn't negatively impact my work. I mean that is the truth. And we can go round and round about the system setting the supervisors to fail, and believe me, I think that's true. For real. But I am out there dealing with some tough shit and who has my back?

**Informant 6:** Your partner. Your team does. I think that I mean I would like supervision more but at the same time I feel like I am doing ok. My supervisor will never know me like my team does anyway.

**Informant 5:** I really still think that if two people are drowning and one is able to keep themselves afloat, for lack of a better analogy, wouldn't we save the drowning people? I mean that is crisis 101.

**Informant 1:** I mean are you kidding? People, people drowning? Why aren't we teaching people to freaking swim and make sure they know how to do that and then it wouldn't have to be so drastic that they would drown.

**Informant 3:** Yeah, I mean the drowning thing doesn't do it for me.

**Informant 2:** I think some of us agree on this and some of us don't so . . .

**Informant 5:** Yeah, maybe we should move to the next theme. Supervision expectations include self-care, professional development, case consultation, and team-building. What do you all think?

**Informant 6:** I think team building or team supervision would be so freaking nice. I mean to be able to sit with our partners and work through some stuff would only make us better on calls. A, like a, what I am trying to say? Oh, like a third party.

**Informant 5:** I agree team building would be wonderful.

**Informant 2:** For me, self-care is first on that list. I mean at some point without that none of the other stuff matters. Like, "heard you saw someone die today. Must have been rough." I mean at our place sometimes there is debriefing but it's with a stranger, not your supervisor, which is really, I don't know, awkward.

**Informant 4:** I think all of those things would be needed in like, a total well-rounded supervision. I want to talk about my cases, good and bad, I want to grow in my skill set, I want to work better with my partner, and I want to make sure I am ok so I'm not carrying stuff with me. Like all of those components are necessary. The thing is if those are the expectations then reviews wouldn't suck so much, 'cause we would know along the way instead of only at review time.

**Informant 3:** Well I think I spoke to this earlier. I need to know that self-care is a priority in my eyes and my supervisor's. Like if you want me to keep running and doing my job you have to refuel me in some way. Some days I feel like I am running on empty.

**Informant 5:** I can appreciate that. I think I've been there, too. I try to reach out to my team in that moment the most. But it's a challenge for sure. Oh look this next theme we

probably should have, um, done with the other two. The lack of supervision leads to questioning evaluative component of supervision. I mean this one is a little hard for me as I read it. And I will be honest, prior I didn't think much of this. Like how they judge or evaluate me, which they have to do, if they don't really sit with me. That makes me uncomfortable hearing it that way.

**Informant 1:** Right, because what are they evaluating then?

**Informant 3:** Yeah, I mean for us we do a self-eval and then they do theirs and we talk about both usually. I have found that mine match theirs. So I don't if that's because we actually agree or they used mine as a guide when filling it out.

**Informant 1:** Do you think your supervisor even knows you?

**Informant 2:** No. Mine doesn't. Like at all. I think that mine has good intentions, but it just lacks follow through.

**Informant 4:** I think it's unethical to truly evaluate someone who you haven't met with or monitored at all. Like, not ok. I mean that is me judging a consumer based on their diagnosis without getting to know the whole person first.

**Informant 6:** You know what, that is a really good point. I hadn't thought of it that way. For me I walk away from this thinking I need to demand some more attention and support.

**Informant 1:** Agreed.

**Informant 3:** Yeah, I think so, too. Well, the last theme is one that we have sort of touched on. Supervision is a system problem because supervisors aren't getting supervision either. This is definitely true. It's a system issue.

**Informant 5:** This is why I have a hard time begin upset about some of this because, like honestly, everyone is busy.

**Informant 2:** Everyone is busy, that is true, but you know what else? I don't feel great if people, like supervisors, even know what they are doing. You know maybe they are burned out and don't want to talk about those cases because they have their own issues. I don't know.

**Informant 4:** Like they would, um, get traumatized by our stories?

**Informant 2:** Maybe.

**Informant 3:** I don't know how I feel about this. It's kind of scary because of the work we do. Like who is looking out for us and who is looking out for the supervisor? I feel kind of alone thinking about this.

**Informant 4:** Yeah, I hear that. I just, for me, it's like no one has time for anyone and that doesn't feel great. We tell people you know, taking care of yourself is most important so you can take care of others. How are we not doing that in a mental health system?

**Informant 5:** I mean that issue is so much bigger than us though.

**Informant 6:** But it directly affects us at the same time.

**Informant 5:** True. (silence) Seems like this all we have for you, I think.

**Interviewer:** Ok, Is there anything else that anyone wants to share before we wrap up?

**Informant 2:** Just thanks. I mean I don't what this does for you but for me it was nice to have time with people who do what I do and vent. Less isolated that way.

**Informant 3:** Yeah, I feel the same way.

**Interviewer:** Good. Good, I am glad that it was helpful. If there is anything else that is needed I will stay back for a few minutes and you guys can see me. For one-on-one



time or anything you don't agree with or if you need support for any reason, I am here and will stay here for another hour to give you, to give you guys that opportunity. Also, I have the transcriptions from your individual interview and want to invite you take a look and make sure everything in there is accurate. That is open to you, so like I said I will just wait here. Otherwise, just to reinforce this is confidential. I will be the only one listening and transcribing the tapes. Your experience has been so valuable to me, not just for the dissertation, but for me as a clinician and as a supervisor, so thank you. Very much.